St Maries Family Medicine

Allergy & Medication List

This form is for children 12 years of age and under

NAME: _____ **DATE OF BIRTH**: _____
DOCTOR: _____
PHARMACY : _____

Allergies	Reactions

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies.

Medication Name Date Started	**Dose** (mg, units, drops)	**When Taken** (daily, at bedtime, etc.)	**Reason for Taking** (blood pressure, diabetes, etc.)

SURGICAL HISTORY

			Date/Additional Information
Tonsil/Adenoids	Yes☐	No☐	**Date and/or year:** _____
Appendectomy	Yes☐	No☐	**Date and/or year:** _____
Gallbladder Removal	Yes☐	No☐	**Date and/or year:** _____
Hernia	Yes☐	No☐	**Date and/or year:** _____
Fracture	Yes☐	No☐	**Date and/or year:** _____ **Location of Fracture**: _____
Other	Yes☐	No☐	**Date and/or year:** _____