

# Allergies and Medications Disclosure

Full Name

Date of Birth

## Allergies

Please list any allergies (e.g., medications, foods, environmental):

## Current Medications

Please list all current medications, including dosage and frequency:

## Additional Notes

Other relevant medical information or concerns:

Date

Signature

*This information is confidential and intended only for healthcare purposes.  
Please notify your provider if any information on this form changes.*