

Medication and Allergy Medical Summary

Patient Information

Name _____

Date of Birth _____

Medical Record # _____

Date _____

Current Medications

Medication Name	Dosage	Frequency	Start Date	Prescribing Physician

* Include all prescription, over-the-counter, and supplement medications.

Allergies

Allergen	Reaction	Severity	Notes

* Include drug, food, and environmental allergies.