Ohio ENT & Allergy Physicians
SLEEP DIVISION

Name: DOB:

Patient Medications

Preferred Pharmacy:________________________ Pharmacy Phone:____________________

Pharmacy Address:____

☐ I am not currently taking any medications (including over the counters, herbals, etc) _____ _____
Initial Date

Medication Name	Route (i.e. oral, etc)	Dose/Strength	Frequency Taken	Reason for taking

Patient Medication Allergies

Are you allergic to latex? Yes___ No___ Are you allergic to medical tape? Yes___ No___

Do you have any know drug allergies? Yes___ No___ If Yes please list all medications you are allergic to below

Medication Name	Reaction

Stop: Sections below to be completed by office staff

Reviewed by	Review Date	Reviewed by	Review