ALLERGIES/MEDICATIONS

BUCKS REHABILITATION SPECIALISTS

PATIENT NAME:	**DOB:**
COMPLETED BY:	**DATE COMPLETED:**

IF NOT COMPLETED BY PATIENT, RELATIONSHIP TO PATIENT:

PHARMACY: _____

ADDRESS: _____

PHONE NUMBER: _____

ALLERGIES/REACTIONS: ☐ **No Known Drug Allergies** ☐ **No Known Allergies**

1. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

2. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

3. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

4. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

5. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

6. ☐ Allergy or ☐ Intolerance ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ S

Reaction:

PRESCRIPTION MEDICATIONS & OVER THE COUNTER MEDICATIONS (INCLUDING HERBALS, VITAMINS, DIETARY AND NUTRITIONAL SUP
SPECIFICALLY NOTE THE USE OF OTC ANALGESICS OR OTC ANTI-INFLAMMATORY MEDICATIONS (IE: MOTRIN, ADVIL, ASP

NAME OF DRUG EX: LYRICA	**STRENGTH** EX: 81 MG	**FORM** IE: CAPSULE, TABLET, CREAM	**ROUTE** IE: ORAL, RECTAL, INHALE, TOPICAL	**DOSE** QTY TAKEN EACH TIME
1.				
Diagnosis/Reason:				
2.				
Diagnosis/Reason:				
3.				
Diagnosis/Reason:				

PRESCRIPTION MEDICATIONS AND OVER THE COUNTER MEDICATIONS CONTINUED				
NAME OF DRUG EX: LYRICA	**STRENGTH** EX: 81 MG	**FORM** IE: CAPSULE, TABLET, CREAM	**ROUTE** IE: ORAL, RECTAL, INHALE, TOPICAL	**DOSE** QTY TAKEN EACH TIME
4.				
Diagnosis/Reason:				
5.				
Diagnosis/Reason:				
6.				
Diagnosis/Reason:				
7.				
Diagnosis/Reason:				
8.				
Diagnosis/Reason:				
9.				
Diagnosis/Reason:				
10.				
Diagnosis/Reason:				
11.				
Diagnosis/Reason:				
12.				
Diagnosis/Reason:				
13.				
Diagnosis/Reason:				

PRESCRIPTION MEDICATIONS AND OVER THE COUNTER MEDICATIONS CONTINUED				
NAME OF DRUG EX: LYRICA	**STRENGTH** EX: 81 MG	**FORM** IE: CAPSULE, TABLET, CREAM	**ROUTE** IE: ORAL, RECTAL, INHALE, TOPICAL	**DOSE** QTY TAKEN EACH TIME
14.				
Diagnosis/Reason:				
15.				
Diagnosis/Reason:				
16.				
Diagnosis/Reason:				
17.				
Diagnosis/Reason:				
18.				
Diagnosis/Reason:				
19.				
Diagnosis/Reason:				
20.				
Diagnosis/Reason:				
23.				
Diagnosis/Reason:				
24.				
Diagnosis/Reason:				

25.				
Diagnosis/Reason:				

PATIENT NAME: _____ DOB: _____ DATE: _____

_____ _____
Severe ☐ Fatal
Severe ☐ Fatal
Severe ☐ Fatal
Severe ☐ Fatal
Severe ☐ Fatal
Severe ☐ Fatal
PLEMENTS) PLEASE IRIN)

FREQUENCY IE: 2x PER DAY; 3x PER WEEK
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC

ALLERGIES/MEDICATIONS

BUCKS REHABILITATION SPECIALISTS

)NTINUED NEXT PAGE

FREQUENCY IE: 2x PER DAY; 3x PER WEEK
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC

)NTINUED NEXT PAGE

FREQUENCY IE: 2x PER DAY; 3x PER WEEK
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC
☐ RX OR ☐ OTC

ALLERGIES/MEDICATIONS

BUCKS REHABILITATION SPECIALISTS

☐ RX OR ☐ OTC

Revised 02/06/2020