R e n o V e i n C l i n i c

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Print Patient Name: _____ Date: _____

I AM ALLERGIC TO:

Drug name or allergen (i.e. - dogs, nuts, cats)	**Reaction** (i.e. - hives, swelling of throat)

CURRENT MEDICATIONS

Do you take aspirin or anti-inflammatory medications ? □ **Yes, list below** □ **No**

Last Taken	***Prescription Medications***	**Dosage**	**How do you take it**	**How often do you take it**	**Why do you take this medication**
Leave Blank	(Example) Lasix	20 mg	By mouth	2 times a day	High blood pressure
Last Taken	**Over-the-counter meds, herbals and nutritional supplements**	**Dosage**	**How do you take it**	**How often do you take it**	**Why do you take this supplement**
Leave Blank	(Example) Multi vitamin	1 tablet	By mouth	1 time a day	Nutritional supplement