

PULMONARY ALLERGY CRITICAL CARE & SLEEP ASSOCIATES

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MEDICATION PROFILE

Name: _____ DOB: _____

Drug Allergies <small>(examples: sulfa drugs, penicillin)</small>	Reaction <small>(examples: rash, rives, nausea, vomiting)</small>
1.	
2.	
3.	
4.	
5.	

Name of Medication <small>(prescriptions, over-the-counter, eye drops, supplements, patches, inhalers)</small>	Dose of Medication <small>(example: one 20mg tablet)</small>	How Often Do You Take This Medication? <small>(examples: three times a day, at bedtime)</small>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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