Proliance
Puget Sound Orthopaedics

Current Medications and Allergies

In our effort to improve patient care and safety, it is required that you complete this list with any current medications you are taking including dosage, how often those medications are taken and the reason for taking them.

PLEASE INCLUDE OVER-THE-COUNTER MEDICATIONS, HERBALS AND DIETARY SUPPLEMENTS.

Please also include any known allergies to medications, latex, iodine, food or metals.

Patient's Printed Name: _____ **Date of Birth:** _____ **Age:**_____

I) CURRENT MEDICATIONS:

Name of Medication	Dosage	How often	Reason	Prescribed By

II) ALLERGIES: _____

_____

III) Have you ever had problems with any type of (local, spinal or general) anesthesia? **YES** ☐ **NO** ☐

If yes, please describe: _____

Please list ALL of your other physicians: _____

I consent to allow my prescriptions to be picked up by:

☐ **I do not wish to release to anyone**

☐ **Spouse:** _____

☐ **Parent:** _____

☐ **Child:** _____

☐ **Other:** _____

Patient's Signature: _____ **Date:** _____

For medical assistant's only **MA's Initials:** _____ **Date:** _____