California Vascular Care

An affiliate of EAST BAY CARDIOVASCULAR & THORACIC ASSOCIATES

Medication List

ALLERGIES:

ARE YOU ALLERGIC TO IODINE, SHRIMP, AND/OR SHELLFISH? ☐ YES ☐ NO

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO

ARE YOU ALLERGIC TO OTHER MEDICATIONS OR FOODS? ☐ YES ☐ NO

Medication Name	Reaction	Medication Name	Reaction
Food Allergies:			
Other Allergies:			

MEDICATIONS:

Please list all prescription medications, over-the-counter medications, vitamins or herbal supplements you are currently taking. Your accuracy in listing the names, dosages, and frequency (how often or time taken) is critical. This list will be used to guide your physician(s) in prescribing medications for you.

Medication Name	Dosage	Frequency	Reason for Taking Medication	Comments (pertinent information regarding how you take medication)

Name (Please Print): _____ **Signature:** _____

Date: _____ **Primary Pharmacy**: _____ **Location:** _____

Reviewed/Verified by: _____ **Date:** _____

(MD, RN)