Allergy Verification Form

Today's Date: ____________ Patient's Name: ____________________ Date of Birth: ________________

Medication Allergies

Complete one column for each medication you're allergic to.

What medication(s) are you allergic to?	**I'm allergic to:**	**I'm allergic to:**	**I'm allergic to:**
When did your allergic reaction happen (# of months or years ago)?			
Why did you take this medication?			
How did you receive the medication (by mouth, IV, on the skin, etc.)?			
What was the dose of the medication (milligrams or grams and number of times per day, if you remember)?			
What type of reaction did you have (rash, hives, itching, trouble breathing, trouble swallowing, stomach upset, etc.)?			
How long did you take the medication before the reaction happened (number of doses, days. or weeks)?			
How long did the reaction last?			
How was the reaction treated (stopped medication, Benadryl, EpiPen, etc.)?			
What other medications did you take around the same time? (Include prescription and over-the counter medications.)			
What other medications have you taken since that were the same or similar (for example, other antibiotics you've taken if you have an antibiotic allergy)?			

Antibiotics History

What antibiotics have you taken in the past that you did **not** have an allergic reaction to? ____________________

When were the last few times you took antibiotics?

Illness	Date	Antibiotic(s) taken

At which pharmacy did you fill your prescriptions?

Name: ______________________

Address: ______________________

Phone: ______________________

Have you ever had surgery? ☐ Yes ☐ No

If yes, complete one row for each surgery:

Surgery	Date	Antibiotics taken (or indicate none taken) (if you remember)

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