JOHN G. PAPAILA M.D. P.A.

ALLERGIES/SENSITIVITIES

List any allergies or sensitivities you have to medicines, foods, or other substances (such as tape). If you do not have any allergies or sensitivities, check the box next to "NO KNOWN ALLERGIES/SENSITIVITIES".

☐ NO KNOWN ALLERGIES/SENSITIVITIES

SUBSTANCE	DESCRIBE WHAT HAPPENS IF YOU TAKE OR ARE EXPOSED TO THIS SUBSTANCE (example: itching and redness)	SUBSTANCE	DESCRIBE WHAT HAPPENS IF YOU TAKE OR ARE EXPOSED TO THIS SUBSTANCE (example: itching and redness)

MEDICATION HISTORY

List **ALL prescription and nonprescription** medications you are currently taking, including over the counter, herbal or diet supplements, aspirin or vitamins. You do not need to enter information in the date or staff columns; our staff will use these columns to update your medication information as necessary.

DATE	MEDICATION NAME	Why are you taking it (ex: high blood pressure) ?	What dose (ex: 500mg) ?	How often do you take it (ex: once a day)?	FOR STAFF ONLY: DATE HELD OR DISCONTINUED	STAFF INITIALS

_____ _____

YOUR SIGNATURE DATE