NEW BEGINNINGS™ OB-GYN

MEDICATIONS/ALLERGIES

(PLEASE PRINT CLEARLY)

Patient Name:	DOB:	Date:

MEDICATIONS/HERBAL SUPPLEMENTS/VITAMINS

Name of Medication	Dose/Strength	How many times a day do you take this?	Why Taking?

ARE YOU ALLERGIC TO ANY MEDICATIONS? (Please also list food and major environmental allergies)

Name of medication	Reaction

ARE YOU ALLERGIC TO LATEX? YES NO

DO YOU HAVE AN EPI-PEN FOR ANY OF THE ABOVE ALLERGIES? YES NO