**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_**

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| **Medication** | **Dose** | **Frequency** | **Start** | **Stop** |
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| **Allergies: Medication** | **Reaction that you had:** |
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| Have you ever had a reaction to dye (contrast) given for an X-Ray, CT scan or imaging study? Yes No |
| Comments |

|  |  |
| --- | --- |
| **Pharmacy:** | **Pharmacy Phone**: |