

Carolina Oncology Specialists, PA Medication List

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Preferred Pharmacy: _____ Telephone Number: _____

Do you have any known drug allergies?: Yes No

If yes, please list:

Name of Drug Allergy	Reaction

Do you have any other allergies? (foods, dyes, environmental, bee stings, etc.) Yes No

If yes, please list:

Name of Other Allergy	Reaction

Please list all medications you are currently taking (include prescription, over-the-counter, vaccines, herbals, vitamins, minerals and diet supplement products).

Medication	Dose	Route	Frequency	Reason for Taking	Date Started	Prescriber

*****Please inform us of any medication changes throughout your care.*****

Employee Signature : _____
(To be signed by staff verifying this medication list)