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)