Allegany Hearing & Balance, LLC

Medication Profile

Patient Name: _____ Age: ____ Date: _____

Please list all prescription medications

Name of Medication	Dosage	Taken How Often?	Taken For What?	Route *(Pill or IV)*

List all over-the-counter medications, vitamins and herbs that are taken on a regular basis

Name of Medication	Dosage	Taken How Often?	Taken For What?	Route *(Pill or IV)*

Are you allergic to any medications? Yes / No

*List:*_____

Any history of chemotherapy or radiation treatment? Yes / No

If yes, please explain: _____

_____

_____

Do you use tobacco products? Yes / No

If yes, what type and amount? _____