ASTHMA & ALLERGY SPECIALISTS

Edward T. McLaughlin, M.D.
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NAME__________________ACCT#___________AGE____DATE__________

Please list ALL medications you are currently taking. INCLUDE medications that were prescribed by other physicians. Remember to include ALL blood pressure medications, sleeping pills, or ANY OTHER MEDICATIONS, PRESCRIBED AND OVER THE COUNTER?

NAME DOSE/HOW OFTEN REASON FOR TX APROX. START DATE

PRESCRIPTION DRUGS:

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NON-PRESCRIPTION DRUGS:

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____

EYE DROPS:

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NOSE SPRAYS:

____
____

VITAMINS:

____
____

SKIN CREAMS, OINTMENTS, LOTIONS:

____
____

DRUG ALLERGIES:			DESCRIBE REACTION TO DRUG
	PENICILLIN:	Y N	____________________
	SULFA:	Y N	____________________
	ASPIRIN:	Y N	____________________
	NOVACAINE:	Y N	____________________

OTHERS:

FORM 3