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RECORD FOR Drug (Medication) Allergy

Patient Name: _____ **Date of birth:** _____

Patient Address: _____

This record is confirmed on DD/MM/YY **by Specialist:** _____ **Signature:** _____

DRUG ALLERGIES FOR ASSESSMENT

Drug	Date of Reaction*	Date of Assessment	Recommendation

PREVIOUS DRUG ALLERGIES (DE-LABELLED)

Drug	Date of De-labelling	Additional Notes

DRUG SIDE EFFECTS AND INTOLERANCES

Drug	Reaction Type	Date of Reaction*	Additional Notes

NOTES:

*If date of reaction is not known, state if it was less or more than five years ago.

If the patient information does not all fit on this page, attach another completed record and indicate number of pages here. Page ___ of ___