SHEFTEL ASSOCIATES, LLP
DERMATOLOGY

IN ORDER TO PROVIDE QUALITY PATIENT CARE IT IS OUR OFFICE POLICY TO REQUEST THAT YOU PLEASE COMPLETE THE MEDICATION/ALLERGY FORM PRIOR TO SEEING THE DOCTOR. PLEASE INCLUDE ALL PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBS, AS WELL AS ALLERGIES. IF YOU HAVE ANY QUESTIONS PLEASE ASK OUR NURSING STAFF WHEN YOU ARRIVE FOR YOUR APPOINTMENT. THANK YOU.

NAME: _____

DATE OF BIRTH : _____

DATE: _____

Current Medication List

On the lines provided, please list all current prescription/over the counter medications you are taking.

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Allergy List

On the lines provided, please list all drug allergies you have**.**

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Local Pharmacy:_____