ASSOCIATED ALLERGISTS AND ASTHMA SPECIALISTS

PRE-OFFICE VISIT FORM

Instructions for patients and parents: DATE: _____

Please fill out this form prior to your office visit and give to an office staff member.

NAME: _____ DATE OF BIRTH: _____
(Last, First)

REASON FOR VISIT: _____

LIST ANY DRUG OR FOOD ALLERGIES: _____

_____

LIST ALL MEDICATIONS (from all doctors). Please include dosages and how often medicine is taken:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PHARMACY INFORMATION:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

WHAT MEDICATION REFILLS DO YOU NEED TODAY?

_____ _____

_____ _____

_____ _____

Thank you!