C03

PROBLEM & MEDICATION LIST

Name: ____ **Birth date:** ____________

Record/ID # ____________

DRUG ALLERGIES					
ALLERGY	DATE	REACTION	ALLERGY	DATE	REACTION
1.			4.		
2.			5.		
3.			6.		

CHRONIC / ONGOING PROBLEMS	DATE NOTED	DIAGNOSIS	DATE RESOLVED	COMMENTS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ACUTE / TEMPORARY PROBLEMS	DATE NOTED	DIAGNOSIS	DATE RESOLVED	COMMENTS
1.				
2.				
3.				
4.				
5.				

CHRONIC MEDICATIONS	DOSAGE / SCHEDULE	START DATE	STOP DATE	COMMENTS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ACUTE MEDICATIONS	DOSAGE / SCHEDULE	START DATE	STOP DATE	COMMENTS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				