ENT and Allergy Associates of Florida
Caring For Our Patients Since 1963
www.entaaf.com

Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ **No Known Drug Allergies**

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please check response: ☐ **Yes** ☐ **No**

Patient/Guardian Signature: _____

Print Patient Name: _____ D.O.B:_____