Medication & Allergy History

Patient Name: _________________________________ Date:__________

I am taking the following Medications: Dosage : Frequency:

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Medicines I am Allergic to: Allergic Reaction:

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In addition to this medication/allergy list, I have recorded my medical history on Maryland Brain, Spine, & Pain's Clinical Intake Questionnaire (Neuro Consult) to the best of my ability. I know this is used by Maryland Brain, Spine & Pain to facilitate my treatment and is also used to monitor my outcome to assure I am getting the best therapy. I am aware that, at any time, I may be asked to answer the same scaled or graded questions or to update my Questionnaire. I have been assured my medical record is confidential.

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Patient Signature Date