CARY DERMATOLOGY CENTER, P.A.

Patient Name_____ Date of Birth: _____

Please list any **Medication Allergies**: _____

_____

_____

LIST OF CURRENT MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescriptions, over the counter, herbal, vitamin and diet supplement products. Also list any medicine you take only on occasion.

MEDICATION	STRENGTH