Foundation Foot & Ankle

Medication List

Patient Name:________________________________ Date of Birth:_______________

Please list **all** over-the-counter **and** prescribed medications

Name of medication / vitamin / supplement:	**Dose**

I consent to have my prescription history electronically transmitted directly to Foundation Foot & Ankle, LLC via Surescripts HIPAA compliant secure portal. This consent will remain active, unless it is otherwise cancelled by my written request.

____ __________________

Patient / Responsible Party Date

Did you get a Pneumonia Vaccine?____ When?______ Did you get an Influenza Vaccine?____ When?_______

Previous Hospitalizations / Surgeries

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ALLERGIES: Please check those that apply to you and list type of reaction

___NO KNOWN ALLERGIES ___Cortisone ___Latex ___Sulfa ___Adhesive tape

___Local anesthesia ___Aspirin ___Iodine dye ___Novacaine ___Codeine

___Iodine, topical ___Penicillin ___Other:______________________________

Describe reactions:

____

Med List revised 7/2017