



## Atlanta Cancer Care Current Medications Survey

Dear Patient,

medications and vitamins that you currently take on a regular basis, or once in a while as needed. This should include all prescription and over the counter products recommended by any provider. Please also provide allergy and pharmacy In order to ensure that we have current information regarding medications that you use, please complete the following for all information.

ALIENT NAME AND BIRTHDATE (print):_	DIX I I DA	= (print):				
harmacy name and phone number:	phone nui	nber:				
llergies: I am not allergic to any foods or medications	llergic to a	ny foods or medica	tions			
Vhat are you allergic to?		When was your first allergic reaction to this?		What happened during the allergic reaction?	g the	Mild, moderate, or severe reaction?
rug Name	Strength	Dose You Take	How Often	Date Started	Reasc	Reason for taking medication
					-	