Medication List

Name:	Date of Birth:
Phone number:	Primary Pharmacy:
Emergency contact(s) :	Physicians:

List of Allergies

Medication:	Reaction:

Fluoroquinolone Adverse Reaction(s)

Note: I have taken the fluoroquinolone antibiotic(s): (Check all that apply)

[ ] Cipro/ciprofloxacin [ ] Levaquin/levofloxacin [ ] Avelox/moxifloxacin [ ] Other _____

[ ] Tablets/orally [ ] I.V. [ ] Eye drops [ ] Ear drops [ ] Inhaled

I was prescribed steroid/NSAID medication(s) in conjunction: [ ] Yes [ ] No

I suffered the following adverse reactions:

Additional paper with list of adverse reactions is attached: [ ] Yes [ ] No

PLEASE DO NOT PRESCRIBE ME A FLUOROQUINOLONE ANTIBIOTIC

[ ] under any circumstances [ ] unless I have a life threatening infection and I/my representative express consent

Current Medications

Date started:	Medication name	Dosage	Time of day taken	Reason for medication	Prescribing physician

Supplements and Over the Counter Medications

Date started	Name	Dosage	Time of day taken	Reason for supplement/OTC medication

Additional paper with list of medications and supplements is attached: [ ] Yes [ ] No