



**MID OHIO SURGICAL**  
ASSOCIATES

**Allergies and Medication**

Today's Date \_\_\_\_\_

Patient Name (print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Allergies (medication and environmental)**

None \_\_\_\_\_

Contrast Dye?  yes  no \_\_\_\_\_

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**Current Medication**                      **Dosage**                      **When Taken**

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