

**ALLERGIES & MEDICATION FORM**

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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please list any allergies you have (drugs and other substances):**

Drug/Substance	Reaction

**Please list any current medications (include vitamins): (or provide copy of medication list)**

Medication	Dosage	Frequency	Method/Route (Ex. By mouth)

**Atlanta**  
980 Johnson Ferry Road  
Suite 1040  
Atlanta, GA 30342

**Cherokee**  
460 Northside Cherokee Blvd.  
Suite 100  
Canton, GA 30115

**Forsyth**  
1505 Northside Blvd.  
Suite 2400  
Cumming, GA 30041