SHERMAN COUNTY MEDICAL CLINIC

Physician, Medication and Allergies

Patient Name: _____ ***DOB:*** _____

Who is your primary care physician? (PCP)

Physician's Name_____Contact Number_____

Office Location:_____ Last visit_____/_____/____

I authorize SCMC to contact and download my medication history electronically and by telephone. This information will become part of my permanent medical record. The information obtained can be used to verify medications and doses, confirm there are no potential contradictions with new medication, verify that prescriptions prescribed are in accordance with clinic policy, obtain information from other providers and other needs to ensure the best health practices for patients.

*Local Pharmacy:*_____ *Mail order Pharmacy:*_____

******Signature***_____ ***Date***_____

Current Medications

Medication Name	Dose/Frequency	Condition	Prescribed by

Allergies to Medications

Name of Medication	Reaction	Date of first onset

Environmental and/or Food Allergies

Allergy to	Reaction	Date of first onset

If you need more room you may use the back of this page.