

**University of Pittsburgh Physicians
Department of Neurological Surgery**

Patient Name: _____

Birth date: _____ Date: _____

Reason for today's visit: _____

Pharmacy Name and Location: _____

Medications (include over the counter medications, vitamins and supplements)

Medication Name	Dosage

Allergies (drug, food, or environmental)

Allergic reaction to:	Reaction

Allergic to:	Y	N	Reaction	Allergic to:	Y	N	Reaction
Shellfish				MRI contrast (dye)			
Iodine				CT contrast (dye)			
Latex				IVP contrast (dye)			
				Angiogram contrast (dye)			