OUTPATIENT ASSESSMENT

Allergy Record

☐ No Known Allergies	Lactating ☐ NO ☐ Yes (If YES, provide copy of anesthetics / sedatives given to patient at Center.)

MEDICATION ALLERGY	REACTION

FOOD ALLERGY	REACTION

OTHER ALLERGY	REACTION
Latex Allergy ☐ NO ☐ YES	

Pre Op Nurse Signature: _____ ***Date:***_____***Time:***_____

Intra Op Nurse Initials:_____ ***PACU Nurse Initials:*** _____

Outpatient Assessment Allergy Record

Patient Label