

Maryland Brain & Spine Medication & Allergy History

Patient Name: _____

Date: _____

I am taking the following Medications:

Dosage

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medicines I am Allergic To:

Allergic Reaction

_____	_____
_____	_____
_____	_____

My medical history is recorded on the Maryland Brain & Spine touch screen computer and is used by the neurosurgeons to facilitate my treatment. It is also used to monitor my outcome to assure I am getting the best therapy. I am aware that Maryland Brain & Spine may ask me to return or will call me to answer the same scaled or graded questions. In that way, we can truly grade the success of my procedure. I have been assured my medical record is confidential.

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date