ROGER J. OLDHAM, M.D. / BETHESDA SURGERY CENTER, LLC

Patient's Name (Please Print): _____

Allergy - (Drug, food, latex and any other)	Type of reaction - (e.g., difficult breathing, rash, etc.)

Name of Medication (Prescribed, over the counter & supplements	Strength (e.g., 50 mg.)	How often medication is taken	Route (e.g., oral, topical, eye drops, etc.)	Reason for Medication

Patient's Signature: Original Date or Update: