Surgical Specialists of Bowling Green, LLC   Michael J. Bielefeld MD * Todd R. Tamlyn MD

NAME: ____   DATE OF BIRTH: ________________

↓ ALLERGIES To: Medications or Other please enter below ↓

Medication ALLERGIES: Drug Name(s):

Other ALLERGIES: List them here:

Medication Name	Dosage	How often taken?	What is the condition your taking the medication for?
Example: Drug name	How many milligrams	1 time a day	Afib, blood clots, High Blood Pressure, High Cholesterol