

# Pre-Surgical Allergy Review Form

## Patient Information

Full Name:

Date of Birth:

Medical Record Number:

## Surgical Information

Scheduled Procedure:

Surgery Date:

## Allergy History

Does the patient have any known allergies?

☐ Yes ☐ No

If yes, list all allergies (medications, foods, latex, etc):

Describe the reaction(s) experienced:

Has the patient had any previous surgical procedures?

☐ Yes ☐ No

If yes, specify procedure(s) and date(s):

## Review & Additional Notes

Reviewed By (Clinician):

Review Date:

Additional Notes / Precautions: