# Allergy Record Form

*This form is used to document a patient's known allergies, including substances, reported symptoms, severity of reactions, and any special remarks. This information is essential for ensuring safe and personalized medical care.*

## Patient Information

* **Full Name:** {fullName}
* **Date of Birth:** {dateOfBirth}
* **Gender:** {gender}
* **Medical Record Number:** {medicalRecordNumber}

## Emergency Contact

* **Name:** {emergencyContactName}
* **Relationship:** {emergencyContactRelationship}
* **Phone Number:** {emergencyContactPhone}

## Allergy Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Allergen** | **Type** | **Reaction Symptoms** | **Severity** | **Notes** |
| {#allergies}{allergen} | {type} | {reaction} | {severity} | {notes}{/allergies} |

## Medications to Avoid

{#medicationsToAvoid}

* {medicationName}

{/medicationsToAvoid}

## Special Instructions

{#specialInstructions}

* {instructionText}

{/specialInstructions}

## Healthcare Provider

* **Provider Name:** {providerName}
* **Facility:** {facilityName}
* **Contact Number:** {providerPhone}

**Date of Record:** {dateCompleted}