Medications Allergies and Immunizations

Today's Date____________________ Patient Name____ DOB__________________

Please Bring All Medications to Your Visit

Prescription Medications –List all medications you are presently taking

Name and Dose	Prescribed by:	How Often	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Non-Prescription Medications –List all medications you are presently taking

Name and Dose	How Often	Date Started
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Current Pharmacy

Name and Location ____ Phone Number ______________

Preferred ____

Other ____

PRISMA HEALTH®

Today's Date__________ Patient Name__________ DOB__________

Allergies – list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

	Allergy	Reaction
1		
2		
3		
4		

List any reactions to bug bites or stings __________

Sexual Activity

Are you sexually active? ❑ Yes ❑ No

If you are sexually active, is your partner ❑ Male or ❑ Female?

Do you use birth control? ❑ Yes ❑ No If yes, what method? __________

Adult Immunizations – Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
❑ Tetanus			
❑ Flu			
❑ Pneumonia			
❑ HPV			
❑ Hepatitis B			

Screenings – List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical		
Full panel of lab work		
Cholesterol (lipid) screening		
Chest X-ray		
Treadmill Stress Test		
Other heart tests		
Colonoscopy		
Mammogram		
Bone Density		