



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 _____



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 _____

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

	Date Received	Others	Date Received
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> 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	_____	_____
	_____	_____
	_____	_____
	_____	_____