



**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	_____	_____
	_____	_____
	_____	_____
	_____	_____