Today's Date _____ Patient Name _____ DOB _____

GREENVILLE HEALTH SYSTEM

MEDICATIONS, ALLERGIES AND IMMUNIZATIONS

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 non-prescription medications you are presently taking. Include over-the-counter medications, vitamins/supplements, herbals, and creams.*

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

CURRENT PHARMACY

	Name & Location	Phone Number
Preferred:		
Other:		

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
☐	Tetanus			
☐	Flu			
☐	Pneumonia			
☐	HPV			
☐	Hepititis B			