

**PRESCRIPTION MEDICATIONS -- List all medications you are presently taking.**

	<u>Name and Dose</u>	<u>Prescribed by:</u>	<u>How Often</u>	<u>Date Started</u>
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.**

	<u>Name and Dose</u>	<u>How Often</u>	<u>Date Started</u>
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

**CURRENT PHARMACY**

	<u>Name &amp; Location</u>	<u>Phone Number</u>
Preferred:	_____	_____
Other:	_____	_____

**ALLERGIES -- List all allergies or unusual reactions you have to medications, foods, dyes, latex, and oth**

	<u>Allergy</u>	<u>Reaction</u>
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.**

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