Allergies

Are you allergic to any medications? Are you allergic to any foods, iodine, tape or latex?

•		
Substance	Reaction	

Pharmacy Name

Pharmacy Phone Number

Vaccine History Check one box for each

vaccine below:

Tetanus				
☐ Within past 10 years				
☐ Unknown				
Pneumonia				
☐ Within past 5 years				
☐ Unknown				
Influenza (Flu)				
☐ Within past year				
☐ Unknown				
Pediatric (for child)				
☐ Up-to-date				
☐ Unknown				

Date form last updated:_____

PERSONAL MEDICATION FORM

Name _____

Date of birth:				
Phone ()				
Ooctor's Name				
Dr Phone ()				
Emergency Contact				
Name				



Phone ()

254130 (12/06)

Medications Please list all prescription and non-prescription medications, herbals, nutritional supplements, eye drops, inhalers, etc that you use. (Cross out medicine name if no longer taking)

Date Started	Name of Medicine	Dose (mg, unit, puffs, drops)	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?