Patient Name: _____ Date: _____

Medications

Medication	Dose	Qty	Frequency	Form						Route					Condition Treating
Name of Medications, Vitamins, OTC Medications			1x daily, Morning & Evenings, Bedtime	Tablet	Capsule	Solution	Suppository	Topical	Other	Orally	Injection	Topical	Rectal	Other	Medical condition being treated by medication listed below?
Ex. Lisinopril	*20mg*	*1*	*1x Morning and 1x Bedtime*	*X*						*X*					*High blood pressure*

Allergies

Medication	Reaction	Date of Onset
Ex. Codeine	*Hives*	*11/1/2011*

Vaccinations:

Influenza Shot	Yes		No		Date Received:	
Pneumonia Shot	Yes		No		Date Received:	