

## 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:

|   |
|---|
| <p style="text-align: center;"><b>Tetanus</b></p> <input type="checkbox"/> Within past 10 years<br><input type="checkbox"/> Unknown     |
| <p style="text-align: center;"><b>Pneumonia</b></p> <input type="checkbox"/> Within past 5 years<br><input type="checkbox"/> Unknown    |
| <p style="text-align: center;"><b>Influenza (Flu)</b></p> <input type="checkbox"/> Within past year<br><input type="checkbox"/> Unknown |
| <p style="text-align: center;"><b>Pediatric (for child)</b></p> <input type="checkbox"/> Up-to-date<br><input type="checkbox"/> Unknown |

Date form last updated: \_\_\_\_\_

## PERSONAL MEDICATION FORM

Name \_\_\_\_\_

Date of birth: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Dr Phone (\_\_\_\_\_) \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

February, 2008



Adopted from  
Legacy Health System

