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 (_____)_____

Doctor's Name_____

Dr Phone (_____)_____

Emergency Contact

Name_____

Phone (_____)_____

February, 2008

Adopted from
Legacy Health System

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?