MEDICATION LIST

Date Form Started: _____

Name:	**Address:**
Phone #:	
Birth Date:	**PHN #:**
Emergency Contact / Phone #:	

IMMUNIZATION RECORD

(Record the date/year of last dose taken, if known.)

TETANUS:	**FLU VACCINE(S):**	
PNEUMONIA VACCINE:	**HEPATITIS VACCINE:**	**OTHER:**

Allergic To / Describe Reaction:	**Allergic To / Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:

Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko)
Include medications taken as needed (example: Nitroglycerin)

MEDICATION / DOSE (Example: Simvastatin 200 mg)	**DIRECTIONS How much I take / When I take it (Example: one tablet at bedtime)**	**REASON FOR TAKING (Example: Cholesterol)**	**DOCTOR'S / PRESCRIBER'S NAME**