MEDICATION FORM

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Name: _____ Date: _____

IMMUNIZATION RECORD (**Record the month/day/year of last dose taken, if known**)

FLU VACCINE(S) _____

PNEUMONIA VACCINE _____

HEPATITIS VACCINE _____

OTHER _____

ALLERGIC TO/DESCRIGE 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).

DATE STARTED	NAME OF MEDICATION	DOSE	FREQUENCY	NOTES: REASON FOR TAKING