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PATIENT MEDICATION HISTORY

NAME: _____ DATE OF BIRTH: _____

ALLERGIES: _____

_____

MEDICATIONS

NAME OF MEDICATIONS	DOSE / STRENGTH	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

NON-PRESCRIPTION MEDICATIONS

1.		
2.		
3.		
4.		
5.		
6.		
7.		

When was your last Pneumonia vaccination? Date: _____ [ ] Unknown

When was your last Flu vaccination? Date: _____ [ ] Unknown

Patient Signature: _____ Date: _____