

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Medications

Medication  Name of Medications, Vitamins, OTC Medications	Dose	Qty	Frequency  1x daily, Morning & Evenings, Bedtime	Form						Route					Condition Treating  Medical condition being treated by medication listed below?
				Tablet	Capsule	Solution	Suppository	Topical	Other	Orally	Injection	Topical	Rectal	Other	
<i>Ex. Lisinopril</i>	20mg	1	1x Morning and 1x Bedtime	X							X				<i>High blood pressure</i>

### Allergies

Medication  <i>Ex. Codeine</i>	Reaction  <i>Hives</i>	Date of Onset  <i>11/1/2011</i>

### Vaccinations:

Influenza Shot	Yes	No	Date Received:	
Pneumonia Shot	Yes	No	Date Received:	