



GENERATIONS

Pediatrics & Internal Medicine

Medications, Allergies and Immunizations

Today's Date _____

Patient Name _____

DOB _____

Please Bring All Medications to Your Visit

Prescription Medications –List all medications you are presently taking

Name and Dose	Prescribed by:	How Often	Date Started
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____
11	_____	_____	_____
12	_____	_____	_____

Non-Prescription Medications –List all medications you are presently taking

Name and Dose	How Often
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____
11	_____
12	_____

Current Pharmacy

Name and Location and Phone _____

Preferred _____

Other _____

Today's Date _____

Patient Name _____

DOB _____



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Allergies - list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

List any reactions to bug bites or stings _____

Adult Immunizations - Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
<input type="checkbox"/> Tetanus	_____		_____
<input type="checkbox"/> Flu	_____		_____
<input type="checkbox"/> Pneumonia	_____		_____
<input type="checkbox"/> Hepatitis B	_____		_____
<input type="checkbox"/> HPV	_____		_____
		<input type="checkbox"/> Hepatitis A	_____
		<input type="checkbox"/> Shingles	_____

Screenings - List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill Stress Test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone Density	_____	_____
Eye exam	_____	_____
Pap smear/ Breast exam	_____	_____
Prostate exam	_____	_____