GREENVILLE HEALTH SYSTEM

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	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Current Pharmacy

Name and Location _____ Phone Number _____

Preferred _____

Other _____

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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
❑ Tetanus			
❑ Flu			
❑ Pneumonia			
❑ HPV			
❑ Hepatitis B			

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		