Medication you are currently taking including vitamins

Name: _____ Date:_____

Date Of Birth _____ Allergies: _____

Pharmacy Name _____ Location _____

Have you had your flu shot yet this year?_____

If age 65 or older, have you had your pneumonia vaccine yet?_____ If YES, when?_____

	Name	Strength	Directions for use	Prescribing Dr.
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