

# MEDICAL HISTORY

Current Pharmacy Name/Number: \_\_\_\_\_

( ) \_\_\_\_\_

## CURRENT / PAST MEDICATIONS

Name	Dose	Frequency	Ending	Physician	Purpose

## SURGICAL PROCEDURES

Date	Procedure	Physician	Hospital	Notes

## MAJOR ILLNESSES

Illness	Start	End	Physician	Treatment Notes

## VACCINATIONS

Name	Date	Name	Date
Tetanus		Meningitis	
Influenza vaccine		Yellow fever	
Zostavax		Polio	
Other vaccine		Other vaccine	