

Confidential Health History Page 3 Patient's Medication Record (use add'l pages as needed)

In Columns 1 thru 4, please List all Prescription and Over the Counter medications you currently take as well as any Vitamins and Herbals. Please use the current date for any for any medication. Include anything that you take on an As Needed Basis (PRN). Medication Name and Dose Examples: Coumadin 2.5mg, Hydrochlorothiazide 12.5mg, Lipitor 10mg, Nitroglycerin 0.4mg, Zocor 20mg. Over the Counter Examples: antacids, Aspirin 325mg, Ibuprofen 200mg. Vitamin & Herbal Examples: multi-vitamins, Ginko 240mg, Garlic 600mg. Please note, Columns 5, 6 and 7 are for Clinic Use. **Please answer the questions at the bottom of the page as well.**

Patient Use				Clinic Use		
1	2	3	4	5	6	7
Current Date	Name and Dose of Medication	# of Times Taken per Day (am, pm, 3 times, etc.)	How is it taken (oral, under the tongue, injection, topical patch, etc.)	Date Patient States Meds Added or Stopped	Date of MD Review (each Exam)	MD Signature or Initials

Patient Use: Additional patient information is required. Please answer the questions below.

Please list the Name, Address & Phone for your Primary Care Doctor (not eye doctor): Name: _____

Address: _____ Phone: _____

Do you use tobacco? Yes No If **Yes**, how long have you been a smoker? _____ yrs How many cigarettes do you smoke a day? _____

If 65 years of age or older, have you ever had a pneumococcal vaccine injection (pneumonia vaccine)? Yes No

Do you receive an Influenza (flu) vaccine every year? Yes No If Yes, when did you receive your last one ? _____

Clinic Use

Reviewed by: _____
 Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D. Patrick P. Sassani, M.D.

Patient Name: _____ Date of Birth: ____/____/____