Today's Date:

Patients Name **Date of Birth:**

Medications

Please list all current medications with all the requested information
(If you do not take any medications please write NONE)

	Medication	Strength	How many times a day?
1.			
2.			
3.			
4.			
5.			

Allergies

Please list all allergies to medications and the reaction you have
(If you do not have any allergies to drugs, please write NONE)

Medication Name	Reaction to medication

Smoking Status (please circle one) ***Current smoker*** ***Former Smoker*** ***Never Smoked***

Alcohol Intake (please answer the following):

Men: How many times in the past year, have you had 5 or more drinks in a day? _____

Women: How many times in the past year, have you had 4 or more drinks in a day? _____

Have you received an influenza immunization? YES NO

Have you received any of the below vaccinations? (please check all that apply)

One - **Tdap** Vaccine _____ ***One*** **- TD** Vaccine _____

One - **Meningococcal** Vaccine _____

Three - **HPV** Vaccinations _____