**NAME:** _____

**D.O.B.** _____ **DATE:** _____

Primary Care Provider:

_____

Reason for your visit today, including duration of symptoms:

_____

Have you had adverse reactions to any prescription medication? If so, what medications

_____

Current medications you are taking prescribed by any doctor:

_____

Current over-the-counter preparations / medications you use:

_____

Have you ever had a pneumonia shot?

_____

Have you had a flu shot for this flu season (August-March)?

_____

Questions you would like to ask during today's visit:

1. _____
2. _____
3. _____
4. _____
5. _____

**OFFICE USE ONLY**

Verified with patient_____ Updated records_____