

PROBLEM LIST / MEDICATION LIST

ALLERGIES/REACTIONS:	Patient Identification
	Name:
	DOB:

SOCIAL HISTORY

Tobacco **Yes ___ No ___** Alcohol **Yes ___ No ___** Substance Abuse **Yes ___ No ___**

Date Onset	Significant Acute & Chronic Conditions (Including Surgical Procedures)	Date Resolved	Medication(s)

ADULT IMMUNIZATION:						
Influenza						
Pnuemococcal						
Hepatitis B						
Diphtheria/Tetanus						
Rubella						