List any allergies to medications or foods that you may have and indicate how each affects you:			
Allergic To	Reaction	Allergic To	Reaction

IMMUNIZATIONS		
Immunization	Date	Recommended
Last Tetanus Booster		Recommended every 10 years
Last Influenza (flu vaccine)		Recommended for age over 65 or with chronic health problems, otherwise optional
Last Pneumovax(pneumonia)		Recommended for age over 65 or with chronic health problems
Last Hepatitis B Vaccine		Required for school age children; optional for adults
Last Skin Test for TB		Was it positive or negative? __________ Recommended if exposed to persons at high risk for having Tuberculosis
Last Measles Mumps Rubella (booster dose)		Recommended for women born after 1965 who plan on becoming pregnant.

Family History

Please indicate with a check any of the following medical problems within your family history

Y = Yourself M= Mother F= Father S= Sister B= Brother GP= Grandparent A= Aunt U= Uncle

	Y	M	F	S/B	GP	A/U		Y	M	F	S/B	GP	A/U
High Blood Pressure							Stroke						
Allergy or Asthma							Obesity						
Heart Attack							Alcoholism						
Diabetes							HIV or AIDS						
High Cholesterol							Glaucoma						
Cancer							Seizures						
Arthritis							Thyroid Disorders						
Kidney Stones							Reaction to Anesthetic						
Bleeding Disorder													