ACTIVE MEDICATION FLOWSHEET

Patient Name		Allergies
VACCINE	INFLUENZA (FLU) □ YES □ NO DATE:	
VACCINE	PNEUMONIA □ YES □ NO DATE:	
VACCINE	SHINGLES □ YES □ NO DATE:	

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

SUPPLEMENTS

SUPPLEMENT NAME	DOSAGE	SUPPLEMENT NAME	DOSAGE

Patient Signature:_____ Date: _____