Rockville Internal Medicine Group **Health Record Information Updates**

Today's Date: _____

Printed Patient Name:_____ **Date of Birth:** _____

MEDICATION ALLERGIES: _____ **No Known Allergies** If yes, complete below:

Drug Name	Reaction

Pharmacy of Choice (Name and location):_____

VACCINES	DATE RECEIVED	Describe Reaction if Any
Flu Vaccine		
Pneumonia Vaccine		
Tetanus Vaccine		
Shingles Vaccine		

Current Medications	DOSE	FREQUENCY	INDICATION

Health Maintenance:	Date		DATE
DEXA Scan – Bone Density			
Colonoscopy			
EGD			
Complete Physical			
PAP			
Mammogram			

Other Physicians that I have seen:

Specialty	Name	Specialty	Name
Internist		Neurosurgeon	
Cardiologist		GI	
Allergist		Urologist	
Pulmonologist		OB/GYN	
ENT		Opthamologist	
Orthopedist		Psychiatrist	
Surgeon		Other	

SURGERY TYPE	DATE	SURGERY TYPE	DATE

Patient Signature:_____ **Date:** _____