Sweetwater Pulmonary Associates

Sandip Desai, M.D.

Name: _____ **D.O.B.:** _____

Address: _____
Pharmacy Name: _____ **Phone:** _____
Pharmacy Address: _____

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)

___ TETANUS _____ ____ HEPATITIS VACCINE _____

___ FLU VACCINE _____ ____ PNEUMONIA VACCINE_____ ___ OTHER _____

Do you have Medication Allergies: ___**YES** ___**NO** If yes, please list and describe

Reaction: _____

Do you have Food Allergies: ___**YES** ___**NO** If yes, please list and describe

Reaction: _____

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING: Prescription and over the counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin)

1. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

2. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

3. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

4. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

16959 Southwest Fwy Suite 100
Phone (832) 255 6632 Fax (832) 255 6633

Name of the Doctor who prescribed it: _____

5. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

6. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

7. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

8. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

9. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____

10. NAME OF MEDICATION: _____

Dose & Directions: _____

Reason for taking the medication: _____

Name of the Doctor who prescribed it: _____