

Adult Preventive Care Flow Sheet

Immunization

Patient Name: _____ Date of Birth: _____

VACCINE	DATE			DATE			DATE			DATE			Total Doses	Diagnosed	Serology	History	Med. Exempt
	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY					
DTP, DTaP, DT, or Td																	
Hepatitis B (Under Age 5) Hip																	
OPV																	
IPV																	
MMR																	
Measles																	
Mumps																	
Rubella																	
Varicella																	

Printed, Type or Stamp
Name, Address and
Telephone # of Licensed
Physician or Health Dept.

Signature : _____