



11. LABORATORY VALUES

TOTAL CHOLESTEROL		TRIGLYCERIDES		DATE OF LAST EYE EXAM		CREATININE CLEARANCE		COMMENTS
LDL CHOLESTEROL		HbA1C		HEART RATE		BONE DENSITY		
HDL CHOLESTEROL		BLOOD PRESSURE		CARDIO RISK		Kidney Function		

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER

ITEM	YES	NO
12. Have you ever had a Comprehensive Medication Review done? If YES, please list pharmacy/clinical pharmacist information.		
13. Do you experience dizziness or light-headedness?		
14. Do you have problems remembering things?		
15. Has your weight changed unexpectedly in the last 3-6 months?		
16. Have you had any problems with bowel movements?		
17. Have you had any problems hearing?		
18. Have you had any incidents involving involuntary urination?		
19. Have you had any falls in the last 4 - 6 months?		
20. Do you feel sad or depressed a majority of the time?		
21. Do you require help in walking, dressing, bathing, getting up/sitting down or shopping, cooking, feeding yourself?		
22. Have you ever suffered from a fracture of any kind?		
23. Do you suffer from any chronic pain?		
24. Do you have an illness that has required you to change your eating habits or amount of food you eat?		
25. Have you lost any height?		
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. If any information was falsified, I agree to hold Pharmacy Practice Associates, PA and any of its employees harmless from any legal action that is brought against them.

24a. TYPED OR PRINTED NAME OF PATIENT	24b. SIGNATURE	24c. DATE
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**NOTE: HAND TO THE CERTIFIED TECHNICIAN OR PHARMACIST, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".**

25. PHARMACIST'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Pharmacist shall comment on all positive answers in items 7 through 11. Pharmacist may develop by interview any additional medical history deemed important, and record any significant findings here.)

26a. TYPED OR PRINTED NAME OF PHARMACIST	26b. SIGNATURE	26c. NPI number	26d. DATE
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