

PHARMACY PRACTICE ASSOCIATES, PA

4095 State Road 7, Suite L-208

Wellington, FL. 33467

Phone # 561-601-5002

Web site: www.medicationmaven.com

PATIENT RECORD		HEALTH INFORMATION AND HISTORY					
NOTE: This information is for official and mee	dically-confident	tial use only and will no	ot be released to unauthorized pers	ons			
1. NAME OF PATIENT (Last, first, middle)			2. PHONE	3. DATE OF BIRTH			
4a. HOME STREET ADDRESS (Street or RFD; City or Town; State,	; and ZIP Code)		5. INSURANCE INFORMATION: (Plan/ID/Group)				
4b. CITY	4c. STATE	4d. ZIP CODE	_				
6a. PRIMARY CARE PHYSICIAN INFORMATION		6b. REASON FOR VISIT (DSM/MTM/SCREENING)					
7. MEDICAL CONDITIONS			1				
a. SOCIAL HISTORY							
EXERCISE			b. ALLERGIES/FOOD	REACTION.			
SPECIAL DIET							
CAFFEINE USE				-			
ALCOHOL USE							
SMOKER							
c. FAMILY HISTORY							
			d. HEIGHT	f. BMI (<24.9, <29.9, > 30)			

NOTES

					e. WEIGHT		g. WAIS	T CIRCUMFE	RENCE
8. HEALTH ISSUES (Pregnant, Nursing, etc.)					9. CAREGIVER CONTACT INFORMATION				
	10.	MEDICATIO	N/OVER THE COUN	TER/HEI	RBAL DRUG	USAGE			
MEDICATION/OTC DRUGS/HERBS	STRENGTH	TIMES/DAY	HOW IS IT TAKEN? (Food/Empty Stomach)	PRE	ESCRIBER	INDICATION		START	N

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" EXI	PLAIN IN E	LANK SPACE TO RIGHT.	LIST EXPLANAT	TION BY ITEM NUMBE	R	
ITEM			YES	NO					
12. Have you ever had a Comprehensive Me please list pharmacy/clinical pharmacist info	edication Review rmation:	done? If YES,							
13. Do you experience dizziness or light-hea	dedness?								
14. Do you have problems remembering thir	igs?				1				
15. Has your weight changed unexpectedly i	n the last 3-6 mc	onths?							
16. Have you had any problems with bowel r	novements?				-				
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 m	onths?								
20. Do you feel sad or depressed a majority	of the time?				-				
21. Do you require help in walking, dressing, shopping, cooking, feeding yourself?	bathing, getting	up/sitting down or			-				
22. Have you ever suffered from a fracture of	f 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			!	!	1				

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				
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