Patient Name: _____ Date: _____

Patient Preferences

Pharmacy (Name of Pharmacy and Location) _____

Name and location of other specialists you may see or have seen (Cardiologist, Endocrinologist, Gastroenterologist, Urologist, Nephrologist, Neurologist, Orthopedic, Psychiatrist, etc.):

_____
_____
_____

Allergies

Allergies	Reaction

Medications

Medication Name	Dosage	Frequency	Prescriber

Vaccines

Vaccination	Date Received	Is date estimated
Tdap (tetanus)		
Influenza		
Pneumonia		
Shingles/ Zostavax		
HPV		

Family Medical History

Disorder/Disease	Family Member	Age of onset	Alive or Deceased	Age of Death	Cause of Death

Patient Surgical History

Surgery	Date	Performing Provider	Notes

Patient Social History

Have you ever smoked or used smokeless tobacco	
Do you currently smoke	
When did you start	
When did you quit	
How much do or did you smoke	
Do you smoke marijuana	
How often and how much	

Alcohol Usage	
How much	
How often	
Do you use any street or rx medications that are no prescribed to you?	

Do you have any advance directives?	

Past Medical History

AIDS/HIV	YES	NO	Depression	YES	NO	Liver Disease	YES	NO
Abuse/Domestic Violence	YES	NO	Developmental or			Lung Disease	YES	NO
Allergies/Hayfever	YES	NO	Behavioral disorder	YES	NO	MRSA exposure	YES	NO
Anemia	YES	NO	Diabetes	YES	NO	Meniere's disease	YES	NO
Anesthesia Complications	YES	NO	Difficulty Swallowing	YES	NO	Mental Disorder	YES	NO
Anxiety Disorder	YES	NO	Diverticulitis	YES	NO	Mental Illness	YES	NO
Arthritis	YES	NO	Ear or			Muscle, Joint, or		
Asthma	YES	NO	Hearing Problems	YES	NO	Bone Problems	YES	NO
Autism Spectrum Disorder	YES	NO	Eating Disorder	YES	NO	Obesity	YES	NO
Bedwetting	YES	NO	Eczema	YES	NO	Osteoporosis	YES	NO
Birth Defects or	YES	NO	Endometriosis	YES	NO	Other	YES	NO
Inherited Disease	YES	NO	Fibromyalgia	YES	NO	Ovarian Cancer	YES	NO
Bladder or Kidney Problems	YES	NO	Gout	YES	NO	Polyps	YES	NO
Blood Diseases	YES	NO	Headaches	YES	NO	Pre-Eclampsia	YES	NO
Blood Transfusion	YES	NO	Heart Disease	YES	NO	Pulmonary Embolism	YES	NO
Breast Cancer	YES	NO	Heart Problems	YES	NO	Reflux/GERD	YES	NO
Breast Problem	YES	NO	Hepatitis	YES	NO	Seizures/Epilepsy	YES	NO
Congestive Heart	YES	NO	High Cholesterol	YES	NO	Skin Problems	YES	NO
Failure (CHF)	YES	NO	Hospitalizations	YES	NO	Stroke	YES	NO
Constipation	YES	NO	Hypertension	YES	NO	Thrombophilias	YES	NO
Coronary Artery Disease	YES	NO	Hyperthyroidism	YES	NO	Thyroid Problems	YES	NO
COPD	YES	NO	Hypothyroidism	YES	NO	Tuberculosis	YES	NO
Cancer	YES	NO	Infertility	YES	NO	Varicosities	YES	NO
Chicken Pox	YES	NO	Kidney Disease	YES	NO	Vision or		
Chronic Ear Infections	YES	NO	Kidney Stones	YES	NO	Eye Problems	YES	NO

Please list here any additional diagnoses or problems that may not be listed above:

_____

_____

_____

_____

I authorize PENSLOW HEALTH CLINIC, INC. to disclose any information pertaining to my healthcare to the following person/persons:

Name	Relationship	Phone number for emergency contact

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____have been given the opportunity to review/receive a copy of Penslow Health Clinic's Notice Of Privacy Practices .

In lieu of patient's signature, I, _____, a staff member of Penslow

Health Clinic, Inc. state that _____has been given our current

Notice of Privacy Practices.

X_____ Date_____

Minor Child Authorization Only

Please list below anyone who is authorization to bring your minor child in for evaluation and treatment. Immunizations and Well-child visits require parent or legal guardian.

Name	Relationship