For Office use Only: Ht: ____ Temp: ____ Pulse:____

Wt: ____ B/P:____ Pulse Ox:____

Patient's Name: ____________________________ Pharmacy Name and Location: _____________________

Date of Birth: ______________________________ Primary Care MD: _______________________________

Today's Date: ______________________________ Referring MD: __________________________________

Change in Address? YES/NO Change in Insurance? YES/NO

Can we leave a message about Lab Results: ___Yes ___No Reminder Email:____________________________

Reason for Visit: _________________________________COVID VACCINATION STATUS: ___________________

Interim Health Events since last visit:

____

____

Medication Allergy/Reaction:

____

____

Current Medications or BRING A CURRENT LIST:

Name	Dosage	Frequency

Review of Systems (PLEASE CIRCLE):

General/Constitutional: fatigue, fevers, headache, recent illness, weight gain or loss

Eyes: contact lenses/glasses, disease or injury, itchy, pain, redness, watering, vision change

Ear/Nose/Throat/Neck: frequent sinus infections, hearing loss, itchy nose, nasal stuffiness, bleeding, pain, post-nasal drip, ringing of ears, runny nose, sneezing, snoring, masses in thyroid

Cardiovascular: chest pain, heart murmurs, or hypertension

Respiratory: cough, respiratory infections, shortness of breath, or wheezing

Gastrointestinal: abdominal pain, constipation, diarrhea, difficulty with swallowing, indigestion/heartburn, nausea, or vomiting

Genitourinary: frequency, infections, or urgency

Musculoskeletal: limitation of motion, pain, swelling

Skin: dryness, eczema, hives, itching, or rash

Neurologic/Psychiatric: anxiety, depression, or seizures

Endocrine: diabetes, glandular problem/thyroid disorder, or intolerance to heat/cold

Hematologic: anemia, bleeding tendency, or previous transfusion and reactions

Allergic/Immunologic: frequent infections, reactions to: foods/insects/medications/vaccines

Up to date on Flu Vaccine? No/Yes, Date: _______________ Smoking: ___Yes ___No ___Prior

Up to date on Pneumonia Vaccine? No/ Yes, Date: _______________ Pregnancy: ___Yes ___No