

Healthy Life Clinic – Patient Data Collection

| Medication Therapy Review | | | | | | | | | | | |
|-------------------------------------------------------------------|---------------------------|----------|--------------------------------------|------------------|--------------------|----------|--|--|--|--|--|
| Patient Information: | | | | | | | | | | | |
| Last Name: | First Nar | me: | | Phone: | | | | | | | |
| Email: | Age: | _ Birth | day: | Race: | Gender: | | | | | | |
| Address: | | | | | | 7in Code | | | | | |
| Stree | T. | | City | Sta | ate | Zip Code | | | | | |
| Primary Physician: | | | Location | Phone Fax | | | | | | | |
| Specialty Physician: | | | | | | | | | | | |
| | | | Location | Phone | | Fax | | | | | |
| Insurance Plan: | | | Member ID: | | | | | | | | |
| Family History: | | | | | | | | | | | |
| List pertinent medical condition | s and illnesses of relati | ves (no | te if deceased): | | | | | | | | |
| Medical Condition | | | tionship (e.g. Mother, | Father, etc.) | Deceased (circle) | | | | | | |
| | | | | | Yes | No | | | | | |
| | | | | | Yes | No | | | | | |
| | | | | | Yes | No | | | | | |
| | | | | | Yes | No | | | | | |
| | | | | | Yes | No | | | | | |
| Past Medical History: | | | | | | | | | | | |
| List medical conditions and/or conspitalizations (note correspond | | of onset | /diagnosis) and any re | ecent illnesses, | surgerie | s, and | | | | | |
| Medical Condition and/or Diagnoses | Date of Onset | | Recent illnesses, Sur Hospitaliza | _ | Corresponding Date | | | | | | |
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| | | | | | | | | | | | |
| Medication Allergies and/or Int | tolerances: | | | | | | | | | | |
| | Rx: | | Med: | Rv | | | | | | | |
| | | | | | | | | | | | |
| Med: | 1\\(\Lambda\). | | Med: | KX. | | | | | | | |





| Social History: | | | | | | | | | | |
|--------------------------------------------------------------------------|-------------------------------|------|---------------------|-------------------------------------------------------------|----------------|-------------|---------------|--|--|--|
| Product | Use (circle |) | If use, what type | ? | Amount per Day | | If Quit, When | | | |
| Tobacco | Yes No | 0 | | | | | | | | |
| Alcohol | Yes No | 0 | | | | | | | | |
| Illicit Drugs | Yes No | 0 | | | | | | | | |
| Caffeine | Yes No | 0 | | | | | | | | |
| Dietary Habits/Restriction | ons: | | | | | | | | | |
| Physical Restrictions: (ci | <i>ircle)</i> Can | e | Walker | Wheelch | nair Ot | her | | | | |
| Physical Activity: | | | | | | | | | | |
| Marital Status: | | | Living Sta | atus: | | | | | | |
| Pharmacy Information: | | | | | | | | | | |
| Pharmacy Name: | | | | Phone: | | | | | | |
| I give consent to get my medication list from the pharmacy listed above: | | | | | | | | | | |
| Signature | | | | | | | | | | |
| Medications (include p | rescription, OT | C, H | erbal, Topical, Ear | and Eye I | Products): | | | | | |
| Name | Name Strength | | Frequency | | Prescriber | | Comments | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| Who manages your me | dications? (cire | cle) | Self or Some | one Else <i>(</i> | explain) _ | | | | | |
| Immunizations (note da | ate received): | | | | | | | | | |
| Influenza: Pneumonia: | | | Shingles: | | | s: | | | | |
| | | | | atitis B: | | | Other: | | | |
| Please fax, email or dro | p form by to C | RMC | C Out-Patient Phar | macy pric | or to sched | luled visit | t: | | | |
| Fax 912-720-9909 | Email: HLC@coffeeregional.org | | | Located on 1 st floor of CRMC near the cafeteria | | | | | | |