# MEDICAL INFORMATION REQUIRED BY MEDICARE:

Patient's Name:______________________________________DOB:_____________Age:________

Race:_________________Preferred Language:____________________Ethnicity: __________

## PHARMACY INFORMATION:

Pharmacy Name:____________________________________________________________

Address:_______________________________________________________________

Phone Number: ( ____)__________________ Allergies to Medicines:____NO_____YES______

If Yes, name medicine(s) and the type(s) of reaction (ie rash, itching, swelling) Explain.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

## HISTORY UPDATE FOR ESTABLISH PATIENT, SINCE YOUR LAST VISIT ( date)

New or Recent Changes to Medications? _____No _____Yes New Alllergies?____NO____YES

Explain:_________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

New Family History?___NO___YES New Surgeries?___NO___YES New Diagnosis___ No___YES

Explain:_________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Did you ever, or do use tobacco products? ____NO____YES Cigarette smoking: Packs per day________

Years of smoking:_____________ If quit, when:___________ Cigar or pipe smoking:____NO_____YES

Do you Drink Alcohol? ____NO____YES what type?:__________ how often?:________ what amount?____

Other Explain:_____________________________________________________________

___________________________________________________________________________

List all New Doctor's Name, Phone Number and last seen involved in your care:________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________