Parkhill Clinic for Women -Dr. Lowry

Name ______________________________ Date: ______________

IMMUNIZATIONS Date: WHAT PHARMACY DO YOU USE?

Influenza Vaccine –

Prevenar – 13/PCV (1st dose) –

COVID 19 (1ST dose) -

COVID 19 (2ND Dose) -

Pneumovax -23/PPSV -

Shingles Vaccine –

Tetanus Vaccine –

PLEASE LIST ALL **MEDICATIONS** AND SUPLEMENTS YOU TAKE: (Dose and Frequency)

Allergies to medications or ANY other allergies:

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Name ____ Date: ___________________

MEDICATIONS
Have you forgotten to take your medications in the last 2 weeks? Y N
Do you have any questions on how/when to take your medication or why it was prescribed? Y N
Do you have any medications that are unaffordable?
Y N
Do you have an unanswered worries or questions related to your medications side effects? Y N

Please List below any side effects to what medication.

Past Surgical History: When and Where?

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Name ____________________________________ Date: ________________

Please list all DOCTORS and SPECIALIST you see:

Have you ever been diagnosed with any new medical problems since last wellness visit?

FOR DIABETICS:

- Retinal Eye Exam (not just vision check):

When:	Where?

- Foot Exam:

When:	Where?

FOR PATIENTS WITH CARDIOVASCULAR DISEASE:

- Are you currently taking a cholesterol medication? Y N

PREGNANCIES:

Number of pregnancies		Number of miscarriages or abortions		Number of living children	

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Wellness Screenings

PCP Wellness Exam:
When:_________________Where: _________________
Colonoscopy/Colorectal Cancer screening:
When:_________________ Where: _________________
Bone Density:
When: _________________Where: _________________
Pap Smear/Cervical Cancer:
When: _________________Where: _________________
Screening Mammogram/Breast Cancer Screening:
When:_________________Where:_________________

SUBSTANCE USE TOBACCO (Circle): NEVER
Cigarettes Cigars Pipe Vape/E-Cig smokeless/Dip/Chew/Snuff
Current daily / Current / Current some days
Former (Year you quit):
How long did you use?

ALCOHOL (Circle): NEVER
Beer / Wine / Hard liquor / other
Current daily / Current someday
Former (Year you quit):
How much do/did you use?

RECREATIONAL DRUGS (Circle): NEVER
Current daily / Current Someday
Former (Year you quit):
How long did you use? Type(s):

PAST Personal Medical (P) and Family (F) HISTORY (Please list family members)

	P	F		P	F		P	F
ADHD/ADD	☐	☐	Heart Disease	☐	☐	Osteopenia	☐	☐
Alzheimer's Disease	☐	☐	High blood pressure	☐	☐	PMS	☐	☐
Arthritis	☐	☐	High cholesterol	☐	☐	Stroke	☐	☐
Anemia	☐	☐	HX of miscarriage	☐	☐	Sudden death	☐	☐
Anxiety/Depression	☐	☐	Hyperthyroid	☐	☐	TB	☐	☐
Bleeding Disorder	☐	☐	Hypothyroid	☐	☐	**TYPE OF CANCER:**	☐	☐
Blood clot	☐	☐	Infertility	☐	☐	Breast cancer	☐	☐
Diabetes (Type 1 or 2)	☐	☐	Pelvic Inflammatory Disease	☐	☐	Ovarian cancer	☐	☐
Endometriosis	☐	☐	Obesity	☐	☐	Colon cancer	☐	☐
COVID 19	☐	☐	Autoimmune disease	☐	☐	Other:	☐	☐

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Name ____ Date: ____________________

REVIEW OF SYSTEMS

CONSTITUTIONAL

Fatigue ☐ Fever ☐ Chills ☐ Weight loss ☐ Night sweats ☐ Easy bruising ☐
TB Exposure ☐ Loss of appetite ☐ Headaches ☐ Blurried Vision ☐
Additional Symptoms: ____

CARDIOVASCULAR

Chest pain ☐ Irregular heartbeats ☐ Rapid heart rate ☐ Syncope ☐ Varicosities ☐
Cyanosis ☐ Lower extremity edema ☐
Additional Symptoms: ____

GASTROINTESTINAL

Nausea/Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Constipation ☐ Heartburn ☐
Hemorroids ☐ Dysphagia ☐ Abdominal pain ☐
Additional Symptoms: ____

GENITOURINARY

Urgency/Frequency ☐ Foul odor ☐ Pain with urination ☐ Hematuria ☐ Incontiencence ☐
Urninary retention ☐ Vaginal discharge ☐ Vaginal itching ☐ Stress incontinence ☐
Additional Symptoms: ____

INTEGUMENT

Rash ☐ Itching ☐ Hair growth change ☐ New skin lesions ☐ Acne ☐
Additional Symptoms: ____

NEUROLOGIC

Muscular weakness ☐ Memory difficulties ☐ Seizures ☐ Tingling or numbness ☐
Diffculty concentrating ☐ Speech difficulites ☐
Additonal symptoms: ____

ENDOCRINE

Loss of hair ☐ Cold intolerance ☐ Hirsutism ☐ Hot flashes ☐
Additional symptoms: ____

PSYCHIATRIC

Anxiety ☐ Depression ☐ Hearing problems ☐ Difficulty sleeping ☐ Suicidal ideations ☐
Additional Symptoms: ____

EYES, EARS, NOSE, AND THROAT

Vision problems ☐ Hearing pronlems ☐ Sinus trouble ☐ Hay fever ☐ Nosebleeds ☐
Sore throat ☐ hoarseness ☐ Lumps in neck ☐ Tooth problems ☐
Additional Symptoms: ____

RESPIRATORY

Cough ☐ Cough blood ☐ Wheezing ☐ Asthma/COPD ☐ Emphysema ☐ Bronchitis ☐
TB Exposure ☐ Shortness of breath ☐
Additional Symptoms: ____