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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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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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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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 stoo ☐ 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: _____

PARKHILL CLINIC FOR WOMEN

PATIENT AUTHORIZATION FOR STUDENT OBSERVATION

Parkhill Clinic for Women participates in clinical education programs with area colleges and universities to give students engaged in a course study related to a medical career, including nursing students, medical students, interns, and residents (students) experience in clinical practice. Your physician has agreed to permit such students to observe and participate in her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

By signing below, you agree to permit the students working in our office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your physician's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____ _____

Patient Name Patient Signature

Date:_____ Time:_____

_____

Witness Signature

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

This patient, whose name is written about, is a minor, _____ years of age or is otherwise unable to consent to and execute this document for the following reason:

_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

_____ _____

Signature of parent of minor patient, Custodial parent, guardian, or legal Representative

Relationship to patient

Date: _____ Time:_____

_____

Witness Signature