Anthem BlueCross BlueShield Medicaid

Clinical Information Form

Patient name: _____ Date of birth: _____
Address: _____
Phone number: _____

Patient diagnosis	Date diagnosed

Health screens/immunizations	Date performed/results as applicable							
	Date	Result	Date	Result	Date	Result	Date	Result
Cholesterol								
Influenza								
Pneumococcal								
Tetanus								
PSA								
DRE								
Colorectal cancer screening; (Circle test) colonoscopy/sigmoidoscopy/FOB								
Bone density								
Mammogram								
Cervical cancer screening								
Other:								

Surgical history	Habits
	Tobacco:
	Alcohol:
	Drugs:
	Other:
	Pharmacy/Telephone

Allergies: □ NKA

WEBPAKYPEC-0054-16-K August 2016