

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: <input type="checkbox"/> NKA								

<https://mediproviders.anthem.com/ky>

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