Premium Medical Care

□ North □ East □ West □ Lancaster

Print Name _____ **Date of Birth** _____

Phone Number _____ **Arrival Time** _____

Have you been seen at Premium Medical Care in the last year? Yes No

Are you here for a drug screen only? Yes No

If you are here to see the doctor, please complete the information below.

What are we seeing you for today? _____

Are you allergic to any medications? Yes No

If yes, please list _____

Are you taking any medications (over-the-counter or prescription)? Yes No

If yes, please list _____

If the doctor writes you a prescription today, where do you want to pick it up?

Pharmacy Name _____ Location _____

□ I have never smoked.
□ I currently smoke _____ packs per day.
□ I quit smoking _____ years ago.
□ I use chewing tobacco.

Email Address _____@_____.com

DID YOU RECEIVE THE FLU VACCINATION? NO_____ YES_____ WHEN?_____

↓ For staff Use Only ↓

C/O	Ht	Pulse
	Wt	Temp
Duration	BP	Pulse Ox
	Reps	LMP

Is this a new problem? Yes / No

If no, last time seen for the problem _____ At PMC? Y / N

I have reviewed all of the above information. MA Initials _____ Date_____