Patient Information Prior to Review

CONTINUAL CARE™
Medication Therapy Management

Name		Date of Birth	
Address			
City		State	Zip
E-mail address		Home Phone	Cell Phone
Insurance		ID#	
Social Security #		Date Form Completed	
Height	Weight	Race (optional): ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Native American ☐ Other:	

Social History

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Family History

☐ High Blood Pressure	☐ Diabetes	☐ High Cholesterol
☐ Heart Attack	☐ Stroke	☐ Kidney Disease
☐ Depression	☐ Cancer	☐ Other:

Past Medical History		Past Surgical History
☐ Asthma	☐ High Blood Pressure	☐ Appendectomy
☐ Irregular Heartbeat	☐ Heart Attack	☐ Angioplasty or stent
☐ Anxiety	☐ GERD (acid reflux)	☐ Hip Replacement
☐ COPD	☐ Ulcers (stomach/instestine)	☐ Hysterectomy
☐ Diabetes	☐ Thyroid disease	☐ Knee replacement
☐ Depression	☐ Stroke	☐ Pacemaker/defribrillator
☐ High Cholesterol	☐ Cancer	☐ Live births #

☐ Other:_____

Does the patient smoke or use tobacco products? Y / N

If so, what type? _____ For how long? _____ How much per day? _____

Does this patient drink alcoholic beverages? Y / N

If so, what type? _____ How much or how often? _____

Does this patient drink caffeinated beverages? Y / N

If so, what type? _____ How much or how often? _____

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Current Medications			
Name/Strength	**How Is It Taken?**	**What Is It For?**	**For How Long?**

Allergies/Adverse Drug Reactions	
Medication	**What Happened**

Doctor Information		
Doctor Name	**What Type Of Doctor**	**Phone #**

Pharmacy Information`	
Pharmacy Name	**Phone #**

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