



PORT RICHEY HEALTH CENTER

PRICARE LLC

Patient's Information

Patient's Name: _____

Date of Birth: _____ SEX: M/F

E-Mail: _____

Preferred Pharmacy: _____

Single/ Married / Divorced / Separated

Tobacco Use: Y/N How Many Packs /Day? _____ Per _____ Day

Alcohol Use: Y/N How Many Drinks/Day? _____ Per _____ Day

Drug Use: Y/N Drug of Choice: _____

Current Medical History: High Blood Pressure, Diabetes...

Past Surgical History:

Family History: Mother, Father, Grandparents

Reason For Today's Visit: _____

Medication Allergies:

Current Medication List:

Patient's Signature: _____ Date: _____