

**Clinical Information Form**

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 Patient Name

<b>PATIENT DIAGNOSES</b>	<b>DATE DIAGNOSED</b>

<b>HEALTH SCREENS</b>	<b>DATE PERFORMED</b>				
RECTAL EXAM					
PSA					
CHEST X-RAY					
SIGMOIDOSCOPY					
EKG					

<b>SURGICAL HISTORY</b>	<b>HABITS</b>

**PHARMACY/TELEPHONE**
