AMERIGROUP Community Care

Clinical Information Form

Patient Name: _____ DOB: _____
Address: _____
Phone Number:_____

Patient Diagnoses	**Date Diagnosed**

Health Screens /Immunizations	**Date Performed**				
Cholesterol					
Influenza					
Pneumococcal					
Tetanus					
Colorectal Cancer Screening; (Circle test given) Colonoscopy/Sigmoidoscopy/DCBE/FOB					
Bone Density					
Mammogram					
Cervical Cancer Screening					
Other:					

Surgical History	**Habits**
	Tobacco:
	Alcohol:
	Drugs:
	Other:
	Pharmacy/Telephone

Allergies: □ NKA