



ANAHEIM MARKET CLINIC



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SUMMARY OF CARE

Patient Name: _____

DOB: _____

Drug Allergy: _____

| No | Current Medication | Start Date | Stop Date | Refill | | | |
|----|--------------------|------------|-----------|--------|--|--|--|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |

| Date | Specialist / Name | Reason | Feedback | Plan | Notes |
|------|-------------------|--------|----------|------|-------|
| | | | | | |
| | | | | | |
| | | | | | |

| No | Hospitalization / Surgery | Date | Health Maintenance | Date |
|----|---------------------------|------|--------------------|------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

| Annual | Year | Year | Annual | | |
|--------------|------|------|-----------------|--|--|
| Bone Density | | | Physical | | |
| Mammogram | | | Lipid Profile | | |
| Pap Smear | | | Hb Alc | | |
| Stool Guaic | | | Carotid Doppler | | |
| PSA | | | DVT | | |

Contact Name: _____

Phone: _____

Comments: