MEDICAL HISTORY AND ANNUAL PHYSICAL FORM

3537 N Anthony Blvd
Fort Wayne, IN 46805
(260) 373-1083
(260) 739-3927
covid.care.now@gmail.com

Patient Information

Today's Date:

First: Last: DOB: Phone:

Please list all allergies:

If you are female, are you pregnant now, or planning to become pregnant: ☐ Y ☐ N

Have you had COVID, if Yes, list date._____ ☐ Y ☐ N Have you ever been hospitalized or had an operation? ☐ Y ☐ N

Please explain type of surgery and dates: _____

If you have more medications or medical history than can fit on the form, please write on the back of this form.

MEDICATION NAME--including OTC & herbs	REASON FOR TAKING

PAST MEDICAL HISTORY	DATE

MEDICAL CONDITIONS

Legend: PR=Present, PA=Past

1.GENERAL	PR	PA
Weight Loss	☐	☐
Fatigue	☐	☐
Memory Loss	☐	☐

2.HEENT	PR	PA
Headache	☐	☐
Visual Loss	☐	☐
Decreased Hearing	☐	☐
Sinus Pain	☐	☐
Hoarseness	☐	☐
Sore Throat	☐	☐
Trouble Swallowing	☐	☐

3.RESPIRATORY	PR	PA
Cough	☐	☐
Wheezing	☐	☐

4.BREAST	PR	PA
Breast Mass	☐	☐
Breast Pain	☐	☐
Skin Changes	☐	☐

5.HEMATOLOGY	PR	PA
Anemia	☐	☐
Bleeding Issues	☐	☐

6.CARDIOVASCULAR	PR	PA
Chest Pain	☐	☐
Irregular Heart Beat	☐	☐
Elevated Blood Pressure	☐	☐
Heart Disease	☐	☐
Shortness of Breath	☐	☐
Swelling of Limbs	☐	☐

7.ENDOCRINOLOGY	PR	PA
Diabetes	☐	☐
Excessive Thirst	☐	☐
Excessive Urination	☐	☐
Libido Change	☐	☐

8.GASTROINTESTINAL	PR	PA
Bloody Stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heart Burn	☐	☐
Jaundice	☐	☐
Kidney Stones	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

9.MUSCULOSKELETAL	PR	PA
Joint Pain	☐	☐
Joint Swelling	☐	☐
Jaw Pain	☐	☐

10.NEUROLOGICAL	PR	PA
Blackouts	☐	☐
Dizziness	☐	☐
Seizures	☐	☐
Stroke	☐	☐

11.PSYCHIATRIC	PR	PA
Anxiety	☐	☐
Depression	☐	☐
Sleep Issues	☐	☐

12a. MALE/Genitourinary	PR	PA
Urinary Dribbling	☐	☐
Reduced Flow	☐	☐
Nighttime Urination	☐	☐

12b. FEMALE/Genitourinary	PR	PA
Abnormal Pap Smear	☐	☐
Urinary Complaints	☐	☐
Blood in Urine	☐	☐
Menstrual Irregularities	☐	☐

☐ **I have none of the above medical conditions**

SOCIAL HISTORY

	Never	Present	Past
1.Smoking	☐	☐	☐
Pack Years:_____			
2.Alcohol	☐	☐	☐
Drinks per day: _____			
3.Drugs _____	☐	☐	☐

MISC.

CONDITION	Y	N
Hepatitis A	☐	☐
Hepatitis B	☐	☐
COPD or Emphysema	☐	☐
Cancer	☐	☐
OTHER: _____	☐	☐

TELEMEDICINE CONSULTATION

Reviewed by Dr. Phil Johnson

To the best of my knowledge this is a complete and accurate account of my medical history.

Signature: _____ Date: _____

3 Rivers Pharmacy
3537 N Anthony Blvd
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IVERMECTIN DISCLAIMER

I acknowledge and understand that Ivermectin has been deemed “Highly Not Recommended” by the WHO, FDA, CDC, and NIH. I acknowledge that my Clinicians rely on an appropriate medical and medication history relating to medical conditions and prescribed medications as reported by me as a patient.

Should a patient choose to not disclose their proper medical history, the clinician cannot be held liable nor can any medical license in any state be reviewed or held accountable. We will be explaining, to the best of our ability, the risks in prescribing any medications to the patients to which they must state they understand.

I understand that Ivermectin has not been approved for use for Covid 19 by the FDA at this time

Patient Signature

Print Name

IVERMECTIN
ORDER FORM

Today's Date

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Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Email: _____

Please check your weight from one of these columns

WEIGHT	DOSE	WEIGHT	DOSE	WEIGHT	DOSE	WEIGHT	DOSE
☐ 70-90	8MG	☐ 151-190	16MG	☐ 231-250	22MG	☐ 291-310	28MG
☐ 91-110	10MG	☐ 191-210	18MG	☐ 251-270	24MG	☐ Other: _____	
☐ 111-150	13.5MG	☐ 211-230	20MG	☐ 271-290	26MG		

CHECK ONE BOX BELOW

☐ **I HAVE COVID NOW** ☐ **I DO NOT HAVE COVID NOW**

I WANT TO ORDER THE FOLLOWING

☐ **#15 for $30.00** **Active Covid** Take 2 capsules for 5 days, then 1 every other day until symptoms are gone. ____

☐ **#30 for $50.00** **Prevention Protocol** Take 1 capsule weekly. (30 Capsules = 6 months) ____

The pharmacy can not guarantee potency beyond 6 months because clinical trials have not been conducted.

PRESCRIPTION

☐ **I do not have a prescription** for Ivermectin and need a physician to prescribe it. (Total: $25.00) ____

MAIL OPTIONS

☐ I would like my prescription mailed USPS, for $5.00. It will be sent out in 10-14 business days. ____

☐ I would like to pay a $25.00 expedite fee to have my order filled the same day it is received and I will pick it up at the pharmacy. ____

☐ I would like to pay a $25.00 expedite fee to have my order filled the same day it is received plus, $5.00 USPS standard shipping, mailed same day. ____

☐ I would like to pay a $25.00 expedite fee to have my order filled the same day it is received, plus $25.00 USPS overnight shipping. ____

PLEASE NOTE: We cannot guarantee delivery times because of possible USPS delay that are out of our control. Thanks for understanding. We are happy to help with tracking your package.

Total Billed to Credit Card ____

All Prescriptions Will Be Mailed Unless Other Arrangements Are Made in Advance!

Payment Details

Credit Card Type: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Name on Card _____ Zip Code: _____

Credit Card # _____

Exp Date _____ CCV # _____ **3-digit number on the back of Visa/MC or 4-digit number on the front of AmEx.**

Prescription - Prescriber Use Only

Date: _____ Ivermectin: _____ mg

☐ **PREVENTION** Take 1 capsule now, then 1 in 48 hours, then 1 capsule weekly for prevention. Quantity: #30 (6 month supply)

☐ **ACTIVE COVID** Take 2 capsules (together) daily for 5 days, then 1 every other day until symptoms are gone. Quantity: #15

Total Quantity: # _____ Refill 1x

Phil Johnson, MD
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Fort Wayne, IN 46805

Ph: (260) 422-4757
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_____ May Not Substitute

_____ May Substitute