Please complete and return to your Pharmacy Staff.

To provide the highest level of pharmacy care this information is requested by your Pharmacist or required by state regulation.

Confidential Patient Information

Patient's Last Name (Please Print)	First Name	Middle Initial	Area Code & Home Phone Number: ( ) - -
Street Address		Apartment #	Area Code & Work Phone Number: ( ) - -
City, State & Zip Code			Sex: ☐ M ☐ F / Birthday (Mo., Day, Yr.)
Insurance Information: Cardholder's Name: _____ Relationship to Cardholder: (Circle One) Cardholder, Spouse, Child, Dependent Parent, Other			Social Security Number:
Medications will be dispensed in child resistant packaging unless your request NON CHILD RESISTANT PACKAGING. WOULD YOU LIKE YOUR MEDICATIONS DISPENSED IN NON CHILD RESISTANT PACKAGING? ☐YES ☐NO			E-Mail Address:

Medical Information

Allergies

Please check all known allergies including symptoms experienced:

- ☐ **NO KNOWN ALLERGIES/DRUG REACTIONS**
- ☐ Aspirin I experienced _____
- ☐ Cephalosporins I experienced _____ (ex. Keflex, Celcor)
- ☐ Codeine I experienced _____
- ☐ Erythromycin I experienced _____
- ☐ Food Additives or Dyes _____
- ☐ Penicillins I experienced _____
- ☐ Ibuprofen I experienced _____
- ☐ Morphine I experienced _____
- ☐ Sulfa Drugs I experienced _____
- ☐ Tetracyclines I experienced _____
- ☐ Xanthines I experienced _____ (ex. Theophylline)

OTHER ALLERGIES AND DRUG REACTIONS: _____

_____

Health Conditions

Please check the health condition(s) that apply:

- ☐ Angina
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clotting Disorders
- ☐ Blood Pressure, High
- ☐ Breast Feeding
- ☐ Cancer
- ☐ Cholesterol, High
- ☐ Depression
- ☐ Diabetes (Insulin Dependent)
- ☐ Diabetes (Non-Insulin Dependent)
- ☐ Digestive Conditions
- ☐ Other Health Conditions: _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Hypo-Thyroid Condition
- ☐ Hyper-Thyroid Condition
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Conditions
- ☐ Migraine
- ☐ Parkinson's Disease
- ☐ Pregnancy
- ☐ Prostate Condition
- ☐ Ulcers
- ☐ Other Heath Conditions: _____

Please complete your Profile by indicating any pain relievers, vitamins, herbal products or other non-prescription drugs you use:
(Check all that apply)

Pain Relievers

- ☐ Aspirin
- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil)
- ☐ Naproxen (Aleve)
- ☐ Other OTC: _____
- ☐ Other OTC: _____

Other OTCs

- ☐ Alcohol
- ☐ Antacids
- ☐ Caffeine
- ☐ Cold/allergy
- ☐ Cough Syrup
- ☐ Diet Aids
- ☐ Laxatives
- ☐ Nasal Spray
- ☐ Metamucil
- ☐ Sleep Aids
- ☐ Tobacco
- ☐ Vaginal Cream
- ☐ Other: _____
- ☐ Other: _____

Vitamins/Herbal Supplements

- ☐ Vitamin A
- ☐ Vitamin B/ C Complex
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Calcium
- ☐ Echinacea
- ☐ Garlic
- ☐ Ginko Biloba
- ☐ Ginseng
- ☐ Iron Supplement
- ☐ Multivitamin
- ☐ Minerals
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Since health information may change periodically, please notify your Pharmacist of any new medications (Rx or OTC), allergies, drug reactions or health conditions.

_____ _____

Signature Date Relationship to Patient

I Do Not Wish to Provide This Information _____

Signature Date