KELLEY-ROSS
PHARMACY GROUP
Union Center Pharmacy

PATIENT INFORMATION UPDATE

NAME DATE OF BIRTH SEX: ❑M❑F

ADDRESS

CITY STATE ZIP

EVENING PHONE DAYTIME PHONE

KNOWN MEDICAL CONDITIONS

- ❑ Diabetes
- ❑ Epilepsy (Seizures)
- ❑ Depression
- ❑ Chronic Pain
- ❑ Alzheimer's
- ❑ Liver Conditions
- ❑ Cancer
  Type_____
- ❑ Psoriasis/ Eczema
- ❑ HIV/AIDS
- ❑ Irritable Bowel Syndrome
- ❑ Hepatitis
- ❑ Multiple Sclerosis
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Kidney/ Renal Conditions
- ❑ Glaucoma
- ❑ Asthma
- ❑ Emphysema
- ❑ Acid Reflux (GERD)
- ❑ Stomach/ Peptic Ulcer
- ❑ Hyperlipidemia
  (Elevated cholesterol or triglycerides)
- ❑ Thyroid Condition (Hyper/Hypo)
- ❑ Parkinson's Disease
- ❑ Migraines
- ❑ Hypertension
  (High Blood Pressure)
- ❑ Heart Condition
  Specify_____
- ❑ Osteoporosis
- ❑ Others_____

ALLERGIES

List All Known Allergies, include drugs, penicillin, aspirin, food, peanuts, etc and indicate **type of reaction** (rash, fever, hives, nausea, vomiting, etc)

_____
_____
_____
_____
_____

List any Medication, which you have been told, you cannot take or which you feel you cannot take.

_____
_____
_____
_____

CURRENT MEDICATIONS

List any medication(s) (include over the counter drugs, vitamins, alcohol, tobacco) you use routinely which you do not obtain from us. Please include how often you take it.

_____
_____
_____
_____
_____
_____
_____

Please fill my prescriptions in: ❑ Child Proof **OR** ❑ Easy – Open Containers

I hereby certify that I have received &/or read the Pharmacy's Notice describing how medical information about me may be used & disclosed, & how I can gain access to this information.
I understand the all prescription medications are required to be dispensed in a child-resistant container unless the patient or the patient's agent authorizes the pharmacist to dispense the medication in a regular (non-child-resistant) container. I hereby agree to hold and indemnify the pharmacy and its agents and pharmacists from any loss or damage to any and all third parties from the lack of a child resistant container for any medications for the below named patient which have been authorized and requested in this Release, Hold and Agreement to Indemnify.

_____ _____
Signature Date