PATIENT INFORMATION FORM

LAST NAME: _____

FIRST NAME: _____

MIDDLE INITIAL: _____

ADDRESS: _____

_____

_____

_____

PHONE NUMBER: _____

GENDER: MALE ❑ FEMALE ❑

FOR PHARMACY USE ONLY
_____
_____
_____
_____

ZIP CODE: _____

DATE OF BIRTH: _____

PLEASE CHECK ALL THAT APPLY

MEDICAL HISTORY OF SERIOUS ILLNESS	MEDICATION ALLERGIES
_____ ASTHMA	_____ ANTIHISTAMINES
_____ ARTHRITIS	_____ ASPIRIN
_____ CANCER	_____ BENZODIAZEPINES (VALIUM, XANAX)
_____ DIABETES	_____ CODEINE
_____ EPILEPSY	_____ PENICILLIN
_____ HEART DISEASE	_____ SULFA DRUGS
_____ HIGH BLOOD PRESSURE	_____ TETRACYCLINES
_____ LIVER DISEASE	_____ NSAID'S, MOTRIN, IBUPROFEN
_____ OTHER	_____ ERYTHROMYCIN
	_____ OTHER

OTHER INFORMATION YOU FEEL IS PERTINENT
PLEASE INCLUDE ANY OVER-THE-COUNTER MEDICATIONS PRESENTLY TAKING:

_____

_____

_____

_____

_____ _____

PATIENT'S SIGNATURE DATE

Information collected during this prescription medication interview and consultation will be kept confidential except for that information needed in consultation with your Physician or Pharmacist.
(PLEASE USE OTHER SIDE FOR MORE INFORMATION)

DON'T FORGET - BRING YOUR INSURANCE CARD WITH YOUR PRESCRIPTION