



Confidential Pharmacy Patient Profile

Name: _____

Is this for a pet? Yes No

Sex: Male Female

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Birth date: (mm/dd/yyyy) _____

E-mail: _____

Preferred Container: Child - resistant cap Non – child - resistant cap

Insurance: Yes No

Do you want to enroll in AutoFill: Yes No

Drug Allergies: Yes (Check all that apply) No

<input type="radio"/> Aspirin	<input type="radio"/> Augmentin	<input type="radio"/> Ciprofloxacin	<input type="radio"/> Codeine
<input type="radio"/> Cortisone	<input type="radio"/> Demerol	<input type="radio"/> Erythromycin	<input type="radio"/> Ibuprofen
<input type="radio"/> Morphine	<input type="radio"/> Novocaine	<input type="radio"/> Penicillin	<input type="radio"/> Sulfa
<input type="radio"/> Tetanus	<input type="radio"/> Tetracycline	<input type="radio"/> Other: _____	

Medical Conditions: Yes (Check all that apply) No

<input type="radio"/> Allergies	<input type="radio"/> Anemia	<input type="radio"/> Arthritis	<input type="radio"/> Asthma
<input type="radio"/> Blood clot	<input type="radio"/> Cancer	<input type="radio"/> Depression	<input type="radio"/> Diabetes
<input type="radio"/> Emphysema	<input type="radio"/> Glaucoma	<input type="radio"/> Heart Disease	<input type="radio"/> High Blood Pressure
<input type="radio"/> Kidney Problems	<input type="radio"/> Liver Disease	<input type="radio"/> Lung Disease	<input type="radio"/> Migraine
<input type="radio"/> Pregnancy	<input type="radio"/> Thyroid Disease	<input type="radio"/> Other: _____	

Non-Prescription Medications: Yes (Check all that apply) No

<input type="radio"/> Alcohol	<input type="radio"/> Antacids	<input type="radio"/> Aspirin	<input type="radio"/> Caffeine
<input type="radio"/> Cold/Allergy	<input type="radio"/> Cough Syrup	<input type="radio"/> Diet aids	<input type="radio"/> Ibuprofen
<input type="radio"/> Laxatives	<input type="radio"/> Metamucil	<input type="radio"/> Sleep aids	<input type="radio"/> Tobacco
<input type="radio"/> Tylenol	<input type="radio"/> Vitamins	<input type="radio"/> Other: _____	

Current Medications: _____

Signature: _____

Date: _____