PATIENT HISTORY / ALLERGY FORM

*** This form as well as the release form need to be submitted only on the first order.**

NAME:_____ DATE OF BIRTH: _____

STREET ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

TEL # (DAY): _____ TEL # (EVENING): _____ FAX: _____

LIST KNOWN DRUG ALLERGIES:

1._____
2._____
3._____
4._____

CURRENT MEDICATIONS:
(check box after medication if this is a new medication)

1._____	☐	6._____	☐
2._____	☐	7._____	☐
3._____	☐	8._____	☐
4._____	☐	9._____	☐
5._____	☐	10._____	☐

PATIENT COUNSELLING:

If this is a new medication, would you like to speak to a pharmacist? Yes ☐ No ☐

Signature:_____ Date: _____

Counselling completed
Date:_____

OFFICE USE ONLY