LIST OF MY MEDICATIONS PRIOR TO PHARMACIST CONSULTATION / P. 1

Full Name ____ Date _____________________________

Date of Birth (month, day, year) ____

Address ____

City ____________________________State ___________________ Zip Code _________________________

Your phone number specify home or mobile ____

Other method of contact fax number_____________ or email address _______________________________

Emergency Contact Name __________________________________ Phone Number ____________________

Primary Physician Name ___________________________________ Phone Number ___________________

Other Physician Name ___________________Specialty__________ Phone Number ___________________

Pharmacy(s) Name____ Phone Number(s) _________________

Health Drug Plan/Insurance Name ____________________________ Phone Number __________________

Allergies to medication(s)/foods/others and explain what **reaction(s)** you have:

____

____

Medical History, please list any medical condition(s) that you have been diagnosed or have had in the past:

____

____

Surgical and Lifestyle History, please list any surgery you had:

____

Exercise Y/N___________ if yes, how many times each week________for how long each time _____________

Alcohol Y/N___________ if yes, how many drinks each week ______________________________________

Caffeine Y/N___________ if yes, how many cups each day____

Smoking Y/N___________if yes, how many cigarettes a day ____

Others, please list any available information below:

Last lab results____

Vital Signs ____________________________Height __________ Weight____________________________

Immunizations received ______________________________________ Year _______________________

LIST OF MY MEDICATIONS PRIOR TO PHARMACIST CONSULTATION / P. 2

Medications, please list all your prescription medicines (including samples), non-prescription medications, nutritional supplements as vitamins/minerals, herbal products, eye drops, inhalers, liquids, and topical creams/ointments even if used occasionally:

Name/Dose	How taken	Taken for	Start Date	Doctor Name

Full Name: ____

LIST OF MY MEDICATIONS PRIOR TO PHARMACIST CONSULTATION / P.3

Please list any other medications including the ones only used as needed ____________________________________

____

____

Please list any over the counter items you are currently taking (as Tylenol, Motrin, others)______________________

____

Please list any supplements you are currently taking (as vitamins, minerals, others) ____________________________

____

Please list any herbal products you are currently taking (examples: Echinacea, Ginseng, others)

____

____

- Do you at times miss doses of any of your medications? Y/N If yes, how often? ______________________

- Do you feel that any of the conditions you have are being inadequately treated? Y/N If yes, explain:

____

- Or are you satisfied with your current drug therapy results? Y/N If no, explain______________________________

____

Please rank the following from 1 to 5, with: 1 = most important and 5 = least important to you

_____Avoiding medicine side effects

_____Reducing/managing my symptoms

_____Simplifying my daily dosing schedule

_____Reducing my medication expenses

Full Name:____