

Please complete and return to your Pharmacy Staff.

To provide the highest level of pharmacy care this information is requested by your Pharmacist or required by state regulation.

Confidential Patient Information

Patient's Last Name (Please Print)	First Name	Middle Initial	Area Code & Home Phone Number: () - -	
Street Address		Apartment #	Area Code & Work/Cell Phone Number: () - -	
City, State & Zip Code		E-Mail Address	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birthday (MM/DD/YYYY) / /

Medical Information

<p>Medications will be dispensed in child resistant packaging unless your request NON CHILD RESISTANT PACKAGING. WOULD YOU LIKE YOUR MEDICATIONS DISPENSED IN NON CHILD RESISTANT PACKAGING? (Please initial) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>List All Current Meds: _____</p> <hr/> <p>Allergies Please check all known allergies including symptoms experienced:</p> <p><input type="checkbox"/> NO KNOWN ALLERGIES/DRUG REACTIONS</p> <p><input type="checkbox"/> Aspirin I experienced _____</p> <p><input type="checkbox"/> Cephalosporins I experienced _____ (ex. Keflex, Celcor)</p> <p><input type="checkbox"/> Codeine I experienced _____</p> <p><input type="checkbox"/> Erythromycin I experienced _____</p> <p><input type="checkbox"/> Food Additives or Dyes _____</p> <p><input type="checkbox"/> Penicillins I experienced _____</p> <p><input type="checkbox"/> Ibuprofen I experienced _____</p> <p><input type="checkbox"/> Morphine I experienced _____</p> <p><input type="checkbox"/> Sulfa Drugs I experienced _____</p> <p><input type="checkbox"/> Tetracyclines I experienced _____</p> <p><input type="checkbox"/> Xanthines I experienced _____ (ex. Theophylline)</p> <p>OTHER ALLERGIES AND DRUG REACTIONS: _____</p>	<p>Health Conditions Please check the health condition (s) that apply:</p> <p><input type="checkbox"/> I DON'T WISH TO DISCLOSE MEDICAL CONDITIONS _____ (Initials)</p> <p><input type="checkbox"/> NO KNOWN MEDICAL CONDITIONS</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Angina</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Glaucoma</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Heart Conditions</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Hypo-Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/> Blood Clotting Disorders</td> <td><input type="checkbox"/> Hyper-Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/> Blood Pressure, High</td> <td><input type="checkbox"/> Kidney Disorder</td> </tr> <tr> <td><input type="checkbox"/> Breast Feeding</td> <td><input type="checkbox"/> Liver Disorder</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Lung Conditions</td> </tr> <tr> <td><input type="checkbox"/> Cholesterol, High</td> <td><input type="checkbox"/> Migraine</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Parkinson's Disease</td> </tr> <tr> <td><input type="checkbox"/> Diabetes (Insulin Dependent)</td> <td><input type="checkbox"/> Pregnancy</td> </tr> <tr> <td><input type="checkbox"/> Diabetes (Non-Insulin Dependent)</td> <td><input type="checkbox"/> Prostate Condition</td> </tr> <tr> <td><input type="checkbox"/> Digestive Conditions</td> <td><input type="checkbox"/> Ulcers</td> </tr> <tr> <td><input type="checkbox"/> Emphysema</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other Health Conditions: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypo-Thyroid Condition	<input type="checkbox"/> Blood Clotting Disorders	<input type="checkbox"/> Hyper-Thyroid Condition	<input type="checkbox"/> Blood Pressure, High	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Breast Feeding	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung Conditions	<input type="checkbox"/> Cholesterol, High	<input type="checkbox"/> Migraine	<input type="checkbox"/> Depression	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Diabetes (Insulin Dependent)	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Diabetes (Non-Insulin Dependent)	<input type="checkbox"/> Prostate Condition	<input type="checkbox"/> Digestive Conditions	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Emphysema		<input type="checkbox"/> Other Health Conditions: _____	
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Please complete your Profile by indicating any pain relievers, vitamins, herbal products or other non-prescription drugs you use: (Check all that apply) **I DON'T WISH TO DISCLOSE OTC MEDICATIONS** _____ (Initials)

Pain Relievers	Other OTCs	Vitamins/Herbal Supplements
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Vitamin A
<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Antacids	<input type="checkbox"/> Vitamin B/C Complex
<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Vitamin C
<input type="checkbox"/> Naproxen (Aleve)	<input type="checkbox"/> Cold/allergy	<input type="checkbox"/> Vitamin D
<input type="checkbox"/> Other OTC: _____	<input type="checkbox"/> Cough Syrup	<input type="checkbox"/> Calcium
<input type="checkbox"/> Other OTC: _____	<input type="checkbox"/> Diet Aids	<input type="checkbox"/> Echinacea
	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Garlic
	<input type="checkbox"/> Nasal Spray	<input type="checkbox"/> Ginko Biloba
	<input type="checkbox"/> Metamucil	<input type="checkbox"/> Ginseng
	<input type="checkbox"/> Sleep Aids	<input type="checkbox"/> Iron Supplement
	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Multivitamin
	<input type="checkbox"/> Vaginal Cream	<input type="checkbox"/> Minerals
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
		<input type="checkbox"/> Other: _____

Since health information may change periodically, please notify your Pharmacist of any new medications (Rx or OTC), allergies, drug reactions or health conditions.

Signature	Date	Relationship to Patient
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I Do Not Wish to Provide This Information _____
Signature Date

I would like to opt out of any Promotions or Programs provided by Lakeview Pharmacy _____
Signature Date