Clinic Appointment Date: _____ **Time:** _____

Demographic Information (Please print clearly)	
Full Legal Name:	**Date of Birth:**
Phone Number for a pharmacist to contact you with questions:	

Pharmacy Name (Local, Mail Order)	**Location**	**Phone Number** (Include Area Code)

ALLERGIES to Medications, Foods, Environmental Substances	**TYPE OF REACTION**

Do you react to latex or rubber (gloves, paint, condoms, balloons) with a rash, watery eyes or wheezing? Yes / No

If yes, please explain: _____

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NAME [M]

PT NO [F]

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MEDICATIONS PRESCRIBED BY YOUR DOCTOR			
Medication Name	Strength/ Dose	Directions on the Bottle	Reason for Taking
Example: Lisinopril	*10 mg*	*Take 2 tablets once daily*	*Hypertension*

NON-PRESCRIPTION MEDICATIONS, VITAMINS, MINERALS, HERBALS, OTHER DIETARY SUPPLEMENTS			
Product Name	Strength/ Dose	How Often You Take the Product	Reason for Taking
Example: Calcium Carbonate	*500 mg*	*Once a day*	*Bone health*
Example: Hydrocortisone Cream	*0.1%*	*1-2 times weekly*	*Itchy skin on arm*

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