Chapman Rx Patient Intake Form

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:**
Physical/Street Address **Apartment #** _____ **Mailing Address/PO Box**		**Area Code and Cell Phone Number:**
City, State & Zip Code	**Sex:** ☐ M F ☐	**Birthday:** / /
Insurance Information: **Cardholder's Name:** _____ **Relationship to Cardholder:** _____ **(Circle One) Cardholder, Spouse, Childe, Dependent Parent, Other** Medications will be dispensed in child resistant packaging unless you request NON CHILD RESISTANT PACKAGING **WOULD YOU LIKE YOUR MEDICATIONS DISPENSED IN NON CHILD RESISTANT PACKAGING? ☐ YES ☐ NO**		**Social Security Number:** **Email Address:**

Medical Information

Allergies

Please check all known allergies and symptoms experienced

- ☐ NO KNOWN ALLERGIES/DRUG REACTIONS
- ☐ Aspirin *I experienced* _____
- ☐ Cephalosporins *I experienced* _____
- ☐ Codeine *I experienced* _____
- ☐ Ethromycin *I experienced* _____
- ☐ Food additives/ dyes *I experienced* _____
- ☐ Penicillins *I experienced* _____
- ☐ Ibuprofen *I experienced* _____
- ☐ Morphine *I experienced* _____
- ☐ Sulfa Drugs *I experienced* _____
- ☐ Tetracyclines *I experienced* _____
- ☐ Xanthines *I experienced* _____
- ☐ OTHER ALLERGIES AND DRUG REACTIONS: _____

Health Conditions

Please check the conditions that apply:

- ☐ Angina
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clotting Disorder
- ☐ Blood Pressure, High
- ☐ Breast Feeding
- ☐ Cancer
- ☐ Cholesterol, High
- ☐ Depression
- ☐ Diabetes (Insulin dependent)
- ☐ Diabetes (Non-Insulin Dependent)
- ☐ Digestive Conditions
- ☐ Other Health Conditions _____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Hypo-Thyroid Condition
- ☐ Hyper-Thyroid Condition
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Conditions
- ☐ Migraine
- ☐ Parkinson's Disease
- ☐ Pregnancy
- ☐ Prostate Condition
- ☐ Ulcers
- ☐ Other Health Conditions: _____

Please Complete your profile by indicating any pain relievers, vitamins, herbal products or other non-prescription drugs you use:
(Check all that apply)

Pain Relivers	Other OTC's		Vitamins/ Herbal Supplements	
☐ Aspirin	☐ Alcohol	☐ Nasal Spray	☐ Vitamin A	☐ Ginko Biloba
☐ Acetaminophen (Tylenol)	☐ Antacids	☐ Metamucil	☐ Vitamin B/C Complex	☐ Ginseng
☐ Ibuprofin (Advil)	☐ Caffeine	☐ Sleep Aids	☐ Vitamin C	☐ Iron
☐ Naproxen (Aleve)	☐ Cold/Allergy	☐ Tobaco	☐ Vitamin D	☐ Multivitamin
☐ Other OTC _____	☐ Cough Syrup	☐ Vaginal Cream	☐ Calcium	☐ Minerals
☐ Other OTC _____	☐ Diet Aids	☐ Other:_____	☐ Echinacea	☐ Other: _____
	☐ Laxatives	☐ Other: _____	☐ Garlic	☐ Other: _____

Please notify your Pharmacist of any new medications (Rx or OTC), allergies, drug reactions or health conditions.

Signature: Date: / / Relationship to Patient:

I Do Not Wish to Provide This Information _____

Signature Date

Office Use Only [ ]TY [ ]TYGC [ ]Other