

Name:	Allergies	Reaction
Age:		
Do you smoke? Y / N		
<i>(Please circle one)</i>		

Current Medications

(Please include all current prescription & over-the-counter medications, vitamins & herbal medications)

Medications	Strength	Frequency (How often are you taking the medication & how many are you taking each day?)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Medical History

<i>Please mark all that apply</i>	Do you have any specific concerns you would like to speak with the pharmacist about?
High blood pressure <input type="checkbox"/>	
Diabetes <input type="checkbox"/>	
Heart failure <input type="checkbox"/>	
Osteoarthritis <input type="checkbox"/>	
Rheumatoid arthritis <input type="checkbox"/>	
Osteoporosis <input type="checkbox"/>	
Glaucoma <input type="checkbox"/>	
Other <i>(please list)</i> <input type="checkbox"/>	