PATIENT MEDICATION HISTORY

To help ensure that our patient records are accurate and up-to-date, please complete this form and return it to the pharmacist for processing. This information is vital for prescription processing and will remain strictly confidential.
Thank you for shopping at Solace Pharmacy and Wellness Shop . . .where your good health matters.

Please print. Fill out and bring to Solace Pharmacy and Wellness Shop.

Last Name:_____ First Name:_____ M.I.____

Street/Apt. # _____

City_____ State _____ Zip Code _____

Telephone (_____) _____ Sex: ☐ Male ☐ Female Birth Date_____

Drug Allergies
Please check all that apply.

- ☐ NONE
- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillins
- ☐ Tetracyclines
- ☐ Other

Please Specify_____
_____
_____

Pre-Existing Conditions
Please check all that apply.

- ☐ NONE
- ☐ Angina (I-20.9)
- ☐ Asthma (J-45.909)
- ☐ Diabetes (E-10; E-11)
- ☐ Glaucoma (H-40.9)
- ☐ Heart Disease (I-51.9)
- ☐ High Blood Pressure (I-10)
- ☐ Ulcer; Type of Ulcer _____
- ☐ Other _____

Do you currently take any medications? ☐ Yes ☐ No

If yes, please list_____

_____ (cont. on back)

Do you have a Prescription Insurance Card that pays for your prescriptions? ☐ Yes ☐ No

Name of cardholder:_____ Relationship of Patient to Card Holder: ☐ Self ☐ Spouse ☐ Child

Please present your card to the pharmacist when getting prescriptions filled.

Easy open cap (non-safety cap) on your prescription vials? ☐ No ☐ Yes / Please complete Authorization form.

Would you like to transfer your prescriptions to Solace Pharmacy and Wellness Shop?

☐ Yes, all of them please!!

☐ Yes, List of medications: _____

_____ (cont. on back)

Current Pharmacy Name/Address: _____ Phone:_____

_____ _____
Patient or Guardian Signature Date (mm/dd/yyyy)