PERSONAL INTAKE AND MEDICINE FORM

Med Pack

Pharmacist Initials Completing Medication Review:______ Date:_____________

Name	Date of Birth	Sex (select one)		Height	Weight
		Male	**Female**		

Address	Phone Number(s)	Emergency Contact
	Home:	Name:
	Work:	Relation:
	Mobile:	Phone:

Allergies and Reactions (please describe what happened when you took the medicine)		

Doctor / Dentist / Other Prescriber's Name	Phone Number	Type of Practitioner / Reason for Seeing

Pharmacy Name	Phone Number	Location

Blood Pressure:
Systolic (mmHg):
Diastolic (mmHg):
Method/Date:
Target Goal BP:

Additional Information / Comments

LIST OF CURRENT MEDICINES:

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Medication (Brand and generic Name)	Dose	How and how often you take the medicine	Time(s) of day	Reason for taking	Date started	Date stopped	Doctor Name

Check here if additional pages are attached. [ ]

LIST OF CURRENT MEDICINES (continued):

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Medicine (Brand and generic name)	Dose	How and how often you take the medicine	Time(s) of day	Reason for taking	Date started	Date stopped	Doctor name

Check here if additional pages are attached.