GLENVIEW PROFESSIONAL PHARMACY - PATIENT PROFILE

LAST NAME FIRST NAME MI

STREET/P.O. BOX CITY STATE ZIP MALE / FEMALE (circle one)

SOCIAL SECURITY # DATE OF BIRTH TELEPHONE Home: Work:

HEIGHT________ WEIGHT________ RACE________(Some medications affect people differently according to race)

WOULD YOU LIKE US TO DISPENSE YOUR MEDICATION IN CHILD RESISTANT PACKAGING? YES NO
WOULD YOU LIKE US TO USE GENERIC MEDICATIONS WHERE POSSIBLE? YES NO
DO YOU HAVE PRESCRIPTION INSURANCE? (If yes, please present your insurance card) YES NO
CARDHOLDERS NAME:____________________________________ ID #:______________________________________
RELATIONSHIP TO CARDHOLDER (Circle one): Cardholder, Spouse, Child, Full-time Student, Dependent, Parent, Other

MEDICAL INFORMATION

MEDICAL CONDITIONS (DIAGNOSIS)

( ) Angina
( ) Anemia
( ) Arthritis
( ) Asthma
( ) Blood Clotting disorders
( ) Blood pressure High
( ) Cancer
( ) Central nervous system disorder
( ) Cholesterol,High
( ) Depression
( ) Diabetes (I or II)
( ) Emphysema
( ) Other ____
____
( ) Headaches/Migraine
( ) Heart Conditions
( ) Kidney Disease
( ) Liver Disease
( ) Lung Disease
( ) Nervous disorders
( ) Parkinson's Disease
( ) Ulcers (Stomach or esophagus)

DRUG ALLERGIES AND DRUG REACTIONS

DRUG	REACTION
( ) No known allergies/reactions	
( ) Aspirin	____________
( ) Barbiturates	____________
( ) Cephalosporins	____________
( ) Ceclor, Keflex	____________
( ) Codeine	____________
( ) Demerol	____________
( ) Erythromycin	____________
( ) Macrodantin	____________
( ) Morphine	____________
( ) Penicillins	____________
( ) Phenothiazine	____________
( ) Sulfa Drugs	____________
( ) Tetracyclines	____________
( ) Xanthines	____________
( ) Other	____________

TYPE OF REACTION R=Rash DB=Difficulty Breathing SI=Stomach Irritation ( ) Other ____________

LIFESTYLE INFORMATION

Are you pregnant? YES NO If yes, due date_________. Please notify the Pharmacist if you become pregnant while taking any medications.
Are you breast feeding? YES NO
Do you use tobacco? SMOKE, CHEW, DIP, NONE Do you occasionally consume alcohol? YES NO
List any problems you have been having with your medicine:____
____
For proper drug medication monitoring, please list *present medications* you are currently taking which *were not purchased at this pharmacy:* ____
____
List all *non prescription medications* you are taking: ____
____
Name of physicians and other practitioners you see: ____
____

Since health information may change periodically, I will notify the Pharmacist of any new medication (prescription and non-prescription), any changes in directions of medicines, any new allergies, drug reactions, or health condition changes. I authorize any release of medical information and insurance benefits payments to the above Pharmacy on my behalf.

Signature Date

This information is requested by your Pharmacist as required by state regulations so that he or she can provide appropriate pharmacy services to you. This information will be kept confidential.

I do not wish to complete this form and WILL NOT HOLD THE PHARMACY RESPONSIBLE FOR ADVERSE SIDE EFFECTS I MAY INCUR.

Signature Date