ST. PAUL CORNER DRUG
Pharmacy the way it should be. est. 1922
240 South Snelling Avenue ~ St. Paul, MN 55105
Phone 651 698-8859 Fax 651 698-0005

Confidential New Patient Intake Form

Full Name: _____DOB: _____/_____/_____ Gender: M ☐ F ☐

Social Security # (last 4 digits) XXX-XX-_____

Address: _____ ____Telephone:(_____) _____-_____ H ☐ W ☐Cell ☐

City: _____ ST:_____ Zip:_____Alt Phone: (_____) _____-_____ H☐ W ☐ Cell☐

Email: _____Used for pharmacy-related communication only

Health History

Allergies/Adverse Reactions:_____

_____

***Please include reaction to each (hives, stomach upset, anaphylaxis, etc.)**

Primary Doctor: _____

Please check "Yes" or "No" for each of the following to indicate whether or not the following conditions apply to you:

Yes	No		Yes	No	
☐	☐	High Cholesterol	☐	☐	Hyperthyroidism
☐	☐	High Blood Pressure	☐	☐	Hypothyroidism
☐	☐	Diabetes **Type**: I or II	☐	☐	Anxiety
☐	☐	Environmental Allergies	☐	☐	Depression
☐	☐	Asthma	☐	☐	Migraine/Headache
☐	☐	ADD/ADHD	☐	☐	Epilepsy
☐	☐	Acid Reflux /GERD	☐	☐	Pacemaker
☐	☐	Glaucoma	☐	☐	Pregnant
☐	☐	Colitis/Crohn's Disease	☐	☐	Nursing
☐	☐	Renal Disease	☐	☐	**Other:**_____
☐	☐	Arthritis	☐	☐	**Easy-open Rx bottle caps?**

Please list any medications (prescription and over the counter) that you are currently taking.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please include a copy of your current insurance card(s)