PATIENT MEDICAL HISTORY

Name: ____ Date of Birth: ________________

Date: __________________________ Account #: ______________________________

Pharmacy of Choice and location: ____

Are you diabetic?: _____ yes _____no

ALLERGY

Are you **ALLERGIC** to any **MEDICATIONS**? ____No ____Yes If yes, please list below

____

Other Allergies: ______No ______Yes ( ) **Metal** **( ) Iodine** **( ) Shellfish** **( ) Latex**

Other: ____

MEDICATION HISTORY

Please List **ALL** Medications you are presently taking? (as well as over the counter, herbs, supplements)

Medication	Dosage	Frequency	Prescribing Doctor

Signed by: ____

Patient/Guardian Signature