Patient Name: _____ Date of Birth _____

Preferred Pharmacy Name: _____ Phone Number _____
Pharmacy Address: _____
Do you use a mail-in pharmacy for chronic prescriptions? o Y o N
If yes, Name of Pharmacy _____ Rx Insurance co. _____

MEDICATION PROFILE Please print clearly!

*** PLEASE INCLUDE ANY MEDICATIONS YOU TAKE – FROM ANY SOURCE ***

MEDICATIONS THAT REQUIRE A PRESCRIPTION:

MEDICINE NAME	DOSE/ STRENGTH	HOW OFTEN?	REASON FOR USE?	

OVER THE COUNTER MEDICINES/ SUPPLEMENTS THAT YOU REGULARLY USE:

NAME OF MED/SUPPL.	DOSE	HOW OFTEN?	REASON FOR USE?

IF YOU NEED ADDITIONAL SPACE, PRINT OUT A SECOND PAGE AND MARK HERE: O