

personal medication list

general information:

name: _____

insurance ID #: _____

date of birth: _____

telephone number (including area code): _____

I would like to (select one): talk to a pharmacist by phone

have written recommendations mailed to me

physician name: _____

physician's address: _____

physician's telephone number: _____

known drug allergies: _____

do you have any other prescription drug coverage (i.e., EPIC)? yes no

medication questions:

are you having trouble affording your medications? yes no

are you experiencing any side effects? yes no

if yes, please describe:

do you have any other medication related concerns (be as specific as possible):

health and wellness questions:

are you a smoker? yes no I quit already

do you get regular physical activity (30 minutes at least five times a week)? yes no sometimes

do you incorporate healthy eating into your lifestyle along with medications to manage your disease? yes no sometimes

