Name: _____
Last First Middle

Address: _____
Street City State Zip

Telephone: h: _____ c: _____ Email: _____

Date of Birth: _____ SSN: _____ Sex: MALE FEMALE
(circle one)

Insurance: _____
ID Rx Group Rx BIN Rx PCN

DRUG ALLERGIES

	DRUG	REACTION
☐	No Known Allg	
☐	Penicillin	
☐	Cephalosporins	
☐	Sulfa Drugs	
☐	Erythromycin	
☐	Tetracycline	
☐	Quinalone	
☐	Aspirin	
☐	Anesthetics	
☐	Codeine	
☐	Morphine	
☐	Meperidine	
☐	Egg	
☐	Peanut	
☐	Turmeric	
☐	Food dyes (list)	

MEDICAL CONDITIONS

No Chronic Medical Conditions	☐
Diabetes (250.00, 250.01)	☐
Asthma (493.2)	☐
Heart Disease (429.9)	☐
High Cholesterol (272.0)	☐
High Blood Pressure (401.9)	☐
Blood Clotting Disorder (286.3)	☐
Kidney Disease (588.9)	☐
Liver Disease (573.3)	☐
Stomach Ulcer (531.7)	☐
Anxiety (711.9)	☐
Arthritis (711.9)	☐
Headaches (784.0)	☐
Migraines (346.9)	☐
ADD/ADHD (314.00, 314.01)	☐

Are you PREGNANT or planning to become pregnant in the near future? ☐
Due Date: _____

Preferred Container:
Child-resistant ☐ Easy Open ☐

MEDICATION TRANSFER LIST

Previous Pharmacy:	
Pharmacy Phone #:	
Rx #	Drug Name

I authorize the following people to pick up prescriptions:

_____
_____
_____

_____
signature date

I acknowledge that I have received a copy of Bloomington Drug's Notice Of Privacy Practices. This notice contains information regarding Bloomington Drug's use and disclosure of my personal health information. Since health information may change periodically, I will try to notify the pharmacist of any new medications, changes in directions of medications, new allergies, any drug reactions, and changes in health condition.

_____ _____
Signature of patient/guardian Date: