

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

please include ALL medications you are taking, including prescription, nonprescription, vitamins and herbals.

[illegible]