NEW PATIENT INFO FOR STUDENT HEALTH PHARMACY

Last Name_____First_____Middle _____

Sex: ❑ Male ❑ Female Date of Birth_____Your University ID# _____

Local Physical Address (apt/dorm)_____

_____

Local or Cell Phone #_____ May we text you at this number? ❑ Yes ❑ No

Do you have allergies to any medications? (Please list the medications) _____

_____

Are you currently taking any medications? (Please list the medications, include over-the-counter and herbal products) _____

_____

Do you have any medical conditions? (Please list) _____

_____

Tobacco user: ❑ Current ❑ Former ❑ Never

On a scale of 0 to 10, how would you rate your interest in quitting now? (circle a number)