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) ____

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Tobacco user: ❑ Current ❑ Former ❑ Never

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