



Patient Information Form

Name: _____

Address: _____

Date of Birth: _____ Male Female Day Phone: _____

Night Phone: _____ Other/Cell Phone: _____

How did you hear about Tiger Town? Word of Mouth Newspaper Ad Radio Ad
 Referral - Please indicated from who: _____ Other: _____
 Yellow Pages

I request brand name drugs only.

Do you drink caffeine? Yes No Amount _____
 Are you a smoker? Yes No Amount _____
 Do you drink alcohol? Yes No Amount _____

Do you have any of the following disease states?

- | | | | |
|------------------------|--------------------------|---------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| COPD | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Diabetes | | High Cholesterol | <input type="checkbox"/> |
| -Insulin dependent | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| -Non-insulin dependent | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |

Do you have any medication allergies? Yes No
 If so, to what medication(s)? _____
 What does it do to you? _____

Would you like easy-open containers? (non-childproof) Yes No

Other Medications:

Please list any over the counter medication(s) you are currently taking.

Please list any medication(s) that you get from another pharmacy.

Please list any sample medication(s) that you have received from your physician.

I have read/received a copy of Tiger Town Pharmacy's privacy practices. I understand I will be the only person allowed to pick up medication filled for me - unless I authorize another person to pick it up. I certify that the above information is correct to the best of my knowledge.

Date: _____

Signature: _____