Patient Medication Profile

Hillside Speciality Pharmacy

At Hillside, your safety is important to us. That's why we ask you to provide a current list of your allergies, as well as any medications (prescription, non-prescription, physician samples and/or vaccines) or other over-the-counter products (herbal, vitamin and dietary supplements) you are taking. This will help us monitor your therapy for potentially harmful drug interactions and/or side effects. If you have any questions for your pharmacist or would like to discuss updates to your medication profile, please contact us at 800.803.2523 or the number on your prescription label.

Please do not staple additional sheets to this form.

Patient first name:_____ Last name:_____ Middle initial:_____

Address_____

City_____ State _____ Zip _____

Phone:_____ Start date:_____ Height: _____ Weight: _____

Date of birth:_____ Gender: ☐ Male ☐ Female Pregnant/lactating? ☐ Yes ☐ No

Drug allergies (Please check all that apply):

☐ No known allergies	☐ Ampicillin	☐ Bactrim®	☐ Ibuprofen	☐ Cipro®	☐ Latex
☐ Prochlorperazine	☐ Aspirin	☐ Epinephrine	☐ Tetracycline	☐ Penicillin	
☐ Amoxicillin	☐ Demerol®	☐ Talwin®	☐ Cefaclor/cephalexin	☐ Valium®	
☐ Phenobarbital	☐ Sulfa	☐ Clarithromycin	☐ Tylenol®	☐ Codeine/Percocet®	

Other drug or food allergies:_____

_____

Are you on oxygen? ☐ Yes ☐ No If yes, flow rate:_____

Medical conditions (Please check all that apply):

☐ Diabetes	☐ Kidney dysfunction	☐ Asthma	☐ Psychiatric disorder	☐ Thyroid
☐ Hypertension	☐ Arthritis	☐ Gout	☐ Cystic fibrosis	☐ Depression
☐ Anxiety	☐ Glaucoma	☐ Cancer	☐ Heart disease	☐ Hepatitis/liver disease
☐ Epilepsy	☐ Multiple sclerosis	☐ High cholesterol	☐ HIV/AIDS	☐ Ulcer

Other medical conditions:_____

_____

Current medication profile (Please list all drugs and medical devices that you currently use; more space available on back of form):

Medication/Device	Route	Dose	Directions

Would you like to speak to a pharmacist regarding your medication? ☐ Yes ☐ No

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