Patient Information Medication Therapy Review

RPH Name ____________________
Date ____________________

Patient Name or Identifier ____________________ Date of Birth ____________________

Phone1: ____________ Phone2: ____________ Race: ____________ Sex: M / F

Address: ____

City ____________________ State ____________ Zip ____________

Primary Provider: ____________ Phone: ____________ Fax: ____________

Insurance Plan: ____________ ID Number: ____________ Group# ____________

Goals for Visit:

☐ Comprehensive Review or ☐ Targeted Visit ☐ Identified by Pharmacist or ☐ Referred

If Referred, referred by: ____________________

What questions does the patient have about their medications or disease states?

What is primary concern? Cost Simplification of Regimen Side Effects Other?

Does the patient smoke or use tobacco Products? Y / N
If so, what type? ____________ For how long? ____________ How much per day? ____________

Does the patient drink alcoholic beverages? Y / N
If so, what type? ____________ How much? 1-2/Week 2-6/Week More than 6/week

Does the patient drink caffeinated beverages? Y / N
If so, what type? Coffee Tea Soda Sports Drinks? How much or how often? ____________

Does the patient exercise? Y / N How many minutes day? ____________ days per week? ____________
Weekly Total ____________ Types of exercise: ____________ Interested in More Info? ____________

Ht ____________ Wt ____________ BMI ____________ Waist Circumference ____________

Calories eaten per day? ____________ Food restrictions or allergies? ____________
Calorie Goal ____________ Interested in More Info? ____________

Medication Allergies:

Adverse Drug Reactions(if known):

If treated Goals: BP ____________ Cholesterol ____________ A1C ____________ FBG ____________ INR Range ____________

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Medical Conditions
Please Circle all that apply

Alcoholism
Angina
Anxiety
Arrhythmias
Arthritis
Asthma
Bipolar Disorder
Bladder Problems
Bleeding disorders
Breast feeding
Cancer
Chronic pain
Congestive Heart Failure (CHF)
Constipation
COPD/Emphysema
Coronary Artery Disease
Depression
Diabetes
GERD/Reflux
GI problems
Glaucoma
Gout
Headaches/Migraines

Heart Valve Replacement
Heart Disease
Stents, Pacemaker
Heart Failure
High Cholesterol
High Blood Pressure
Insomnia
Joint Replacement (Knee) (Hip) (Other)
Kidney disease
Liver disease
Obesity
Osteoporosis
Parkinsons Disease
Pregnancy
Prostate Problems
Psoriasis
Seizure disorder
Stomach Ulcer
Thyroid Disorder
Other: ______________________________

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If You have Diabetes, In the last 12 months have you had:

An Eye Exam Yes/No

Dental Exam Yes/No

Foot Exam Yes/No