

635 MAIN STREET



GREEN BAY, WI 54301

COMMUNITY PHARMACY NEW PATIENT FORM

Welcome to Streu's Pharmacy Bay Natural! Please fill out the to following information so we may provide you with the most comprehensive care possible.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ D.O.B. _____ GENDER: _____

For pharmacy use INSURANCE
 ID# _____ GRP# _____ BIN# _____ PCN# _____

PLEASE PROVIDE PREFERENCES FOR RECEIVING YOUR MEDICATIONS:

How would you like your medications packaged? (select one)

In safety-capped BOTTLES In BOTTLES without safety caps

In BLISTER PACKS (circle type preferred below, ask to see samples):

START DATE: _____ **Pickup/Delivery:** _____

Monthly card booklets

Weekly card booklets

Medicine-on-Time® foils



If blister packaged you may be asked to provide preferred times of day you want to take your medications.

Would you like to enroll in MEDSYNC to have RXs aligned & automatically filled (it's free, ask for details)?

Yes, all scheduled meds Yes, but only certain meds (list below) Not now

What other pharmacy do you use, if any? _____

Would you like to transfer other prescriptions here?

___ YES, all ___ NO

___ YES, but just specific ones (list): _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR HEALTH:

1) Who is/are your primary **DOCTOR(s)**: _____

2) Do you have any **DRUG ALLERGIES**? NO ___ YES (please list below)___

Drug allergy

Reaction you had to the drug:

3) Do you have any of the following **MEDICAL CONDITIONS**?

___ Asthma ___ COPD ___ Depression ___ Diabetes ___ Heart Disease

___ High Blood Pressure ___ High Cholesterol ___ Stroke ___ Other (list below)

4) Do you currently **SMOKE**? ___ No ___ Yes, and I want to quit ___ Yes; not ready to quit now

5) Please list the **MEDICATIONS** and **SUPPLEMENTS** you currently take:

6) Have you had a **VACCINE** for any of the following? :

SHINGLES ___ YES (if you know which one(s), please circle below) ___ NO

Shingrix® (new shingles vaccine)

Zostavax® (old shingles vaccine)

PNEUMONIA ___ YES (if you know which one(s), please circle below) ___ NO

Pneumovax® 23

Prevnar 13®

INFLUENZA (flu shot) ___ YES (last year received _____) ___ NO

7) If the patient is a child, please provide their current **weight**: _____ lbs