

Patient Instructions

I. Name _____ Date of Prescription _____

Purpose of Medication: _____

Name of Prescription _____

a. Quantity _____

b. Strength _____

c. Expiration date _____

d. Do not take with _____

e. Prescription Refills at _____

f. Refills _____

II. Directions (Take as directed by your doctor or pharmacist)

How?

1. Take ___ tablets/capsules every ___ hours/days; do not exceed ___ tablets/capsules in 24 hours or as directed by a doctor.
2. Take with: full glass of water / with or without food / take off wrap / dissolve under tongue / suck / take off wrap and place in rectum / take off wrap and insert vaginally / take with or without food.
3. Do not break or crush tablet unless instructed by physician or pharmacist.

When?

1. Take: on an empty stomach / after meal / before meal / with meal
2. Take: in the morning / at bedtime / does not apply

For how long?

1. Stop after: all gone / ____ days (date) / as directed by doctor.

III. Warnings:

- Make sure your pharmacist knows about ALL the medications and herbs you are taking to avoid drug interactions
- Do not share medication
- Do not take together with other medication or herbal medicine
- Do not stop taking medicine before indicated dates of number of doses ordered by pharmacist or doctor
- Throw bottle away after expiration date
- Keep out of reach of children / do not give to children
- Do not exceed recommended dosage. If nervousness, dizziness or sleeplessness occur, discontinue use and call your doctor
- Do not take while driving a motor vehicle or operating machinery if noted by pharmacist or doctor
- Avoid alcoholic drinks, tranquilizers, or sedatives while taking this medicine
- If pregnant or breast feeding, ask your pharmacist or doctor

** If you are uncertain about why you are taking the medicine or how long to take it, be sure to ask your doctor or pharmacist. If you do not speak English well enough, ask for an interpreter.*

Patient History

Name _____ Sex _____ Date _____
Birth Date _____
Patient's Phone Number _____
Pharmacy / Clinic _____
Patient's Language _____ Height _____ Weight _____

Current and Past Patient History

1. Smoking? _____ packs a day
2. Alcohol Consumption? _____ drinks a day
3. Used any street drugs? (marijuana, cocaine, etc.) _____
4. List medications/herbal medicine you are currently taking or have taken in the past:

5. Taking medications currently for:
 - a.) birth control? Y / N List: _____
 - b.) menopause symptoms? Y / N List: _____
 - c.) hormone replacement therapy? Y / N List: _____
6. Last menstrual period? _____ days ago
 - a.) No longer menstruating? Y / N if yes, was it surgical _____ or was it natural _____
7. Food / drug allergies? _____

Check if you currently have or had in the past any of the following

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood clots/phlebitis | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Bowel problems/colitis | <input type="checkbox"/> Sudden shortness of breath |
| <input type="checkbox"/> Breast problems | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Stomach problem? Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Depression or major emotional problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Genetic disease | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Gonorrhea | Past Surgeries: type _____ |
| <input type="checkbox"/> Heart disease problem | Reason _____ |
| <input type="checkbox"/> Hepatitis | Other _____ |
| <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> High triglycerides | |
| <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Kidney Disease | |
- Emergency Number / Contact Person _____

Notes:
