PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Phone Number: _____

Primary Physician Name: _____

Phone Number: _____

Other Physicians, including Specialists

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

ALLERGY INFORMATION

Allergy: _____

What Happened: _____

Allergy: _____

What Happened: _____

Allergy: _____

What Happened: _____

Allergy: _____

What Happened: _____

Allergy: _____

What Happened: _____

VACCINATIONS

☐ Flu: _____

(type and date)

☐ Tetanus: _____

(date)

☐ Tdap: _____

(date)

☐ Pneumococcal: _____

(type and date)

☐ Other: _____ _____

(type) *(date)*

☐ Other: _____ _____

(type) *(date)*

MSHP

MICHIGAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

MPA

MICHIGAN PHARMACISTS ASSOCIATION

Medications and Instructions *(include prescription and nonprescription, herbals, vitamins and supplements)*

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____

MSHP
MICHIGAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

MPA
MICHIGAN PHARMACISTS ASSOCIATION

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____

Visit www.ThatsMyPharmacist.com
to access additional resources.

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____

Drug Name and Strength: _____

_____

Dose: _____

How Often: _____

Reason: _____