RUHS PHARMACY SERVICES
PATIENT INFORMATION FORM

PLEASE COMPLETE THIS FORM AND RETURN IT WITH YOUR PRESCRIPTION. ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE. THANK YOU.

PLEASE PRINT CLEARLY

NAME:_____**SEX: ☐MALE ☐FEMALE**
LAST FIRST MIDDLE

DORM & ROOM # (OR OFF CAMPUS ADDRESS): _____

CITY:_____**STATE:**_____**ZIP CODE:**_____

PHONE #:_____**DATE OF BIRTH:**_____

YEAR OF GRADUATION:_____**STUDENT ID#**_____

IF RUTGERS EMPLOYEE, DEP'T:_____

DO YOU HAVE PRESCRIPTION INSURANCE? ☐YES ☐NO
(IF YES, PLEASE PRESENT THE PRESCRIPTION CARD WITH YOUR PRESCRIPTION)

PLEASE ANSWER THESE IMPORTANT QUESTIONS REGARDING YOUR HEALTH & PRESCRIPTIONS:

1. DO YOU HAVE ANY DRUG ALLERGIES?

☐YES ☐NO

IF YES, PLEASE LIST BELOW

_____
_____
_____
_____
_____
_____

2. DO YOU HAVE ANY CHRONIC CONDITIONS?

☐YES ☐NO

IF YES, PLEASE CHECK THOSE THAT APPLY:

☐ASTHMA **☐DIABETES**
☐GLAUCOMA **☐HEART CONDITION**
☐IBS **☐HIGH BLOOD PRESSURE**
☐OTHER:_____

ARE YOU TAKING ANY KIND OF MEDICATION, BIRTH CONTROL, AND/OR INSULIN AT THE PRESENT TIME? ☐YES ☐NO

IF YES, PLEASE LIST:_____

HOME ADDRESS AND PHONE NUMBER FOR OUR CONFIDENTIAL FILE (IF DIFFERENT FROM ABOVE):

ADDRESS:_____**PHONE #:**_____

CITY:_____**STATE:**_____**ZIP CODE:**_____