Appalachian College of Pharmacy
PATIENT PROFILE/HISTORY FORM

Name: **Gender:** ☐ Male ☐ Female **DOB:**

Address: ***Hm Tele:*** ***Wk Tele:***

Primary Care Provider: ***Specialist:***

Pharmacy: ***Signed Consent Form:*** ☐ ***Yes*** ☐ ***No***

Dosage Forms Available: *(Include color, shape, size, and any special characteristics of the dosage form)*

RX/OTC/ Herbal	*Name/Strength/Route/Frequency*	*Indication*	*Prescriber*	*Start Date*	*Comment: Efficacy/Adherence*

Allergies:

Allergies	*Reaction(s)*	*Allergies*	*Reaction(s)*
Allergy Free (NKDA)		**Penicillin**	
Aspirin		**Sulfa**	
Codeine		**Other: _____**	
Erythromycin		**Other: _____**	

Medical History:

Medical Condition	*Date of Diagnosis*	*Medical Condition*	*Date of Diagnosis*
Arthritis: ☐OA or ☐RA		**Liver disease**	
Asthma		**Menopausal status (☐pre or ☐post)**	
Cancer: ***type*** **_____**		**Migraines**	
COPD		**Osteoporosis**	
Diabetes: (☐type I or ☐type II)		**Seizures**	
Emphysema		**Sexual dysfunction**	
Heart attack		**Stroke**	
Heart failure		**Thyroid disease (☐hypo/ ☐hyper)**	
High Blood Pressure		**Other:**	
High Cholesterol		**Other:**	
Kidney disease		**Other:**	

Personal/Social History:

Height: ft in -or- cm	**Weight:** lbs -or- kg		
Surgical History:			
Family History:			
Nicotine Use:	☐ **Never smoked**	**pack/day for years**	**Stopped**
Caffeine intake:	☐**Does not consume**	**drinks/day ( )**	**Stopped**
Alcohol Consumption:	☐**Does not consume**	**drinks/day ( )**	**Stopped**
Habits/Risk Factors/Drug Use:			
DIET: ☐**Low saturated fat/low cholesterol** ☐**Low sodium** ☐ **Other**			
EXERCISE: ☐ **None minutes times/week**			

Additional Comments:

Student Signature: **Date:**

Preceptor Signature: **Date**: