635 Main Street

Streu's Pharmacy Bay Natural
Advancing Health • Elevating Care

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

For Tech: Transfers Requested ____ This form & HIPAA scanned ____ If BP, added to calendar____ *Please complete other side too >>*