The Pharmacist

32713 County Road 473, Leesburg, FL 34788
Phone (352) 742-8080 / Fax (352) 742-9292

Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ E-Mail: _____
Driver's License Number: _____ SS#: _____

___ Pregnant ___Lactating ___ Nicotine User ___ Alcohol User ___Child Proof Cap

Chronic Medical Conditions

___ Arthritis (M15)
___ Asthma (J45.4)
___ Chronic Bronchitis (J41.0)
___ Chronic Obstructive Pulmonary Disease (J44.9)
___ Congestive Heart Failure (I50.20)
___ Diabetes (NIDDM E11.9 / IDDM E10.9)
___ Emphysema (J43)
___ Hypertension / High Blood Pressure (I10)
___ Hyperlipidemia / High Cholesterol (E78.2)
___ Liver Disease: _____
___ Renal (Kidney) Disease: _____
___ Other: _____

Medication Allergies

___ Aspirin (Salicylates)
___ Codeine
___ Meperidine
___ N Saids
___ Penicillin
___ Sulfa
___ Tetracycline
___ NO KNOWN ALLERGIES
Other Allergies: _____

Please give us a complete list of any other medications you may be taking:

Prescription	Over-the-counter medications	Vitamins / Herbal supplements
_____ - _____	_____ - _____	_____ - _____
_____ - _____	_____ - _____	_____ - _____
_____ - _____	_____ - _____	_____ - _____
_____ - _____	_____ - _____	_____ - _____
_____ - _____	_____ - _____	_____ - _____

Attention Patients: Effective September 23, 2013 The Pharmacist follows the regulations that apply to the privacy of health information. We are required to make available to you our Notice of Privacy Practices during your first visit to our pharmacy and therefore must make a good effort to obtain your signed acknowledgement of providing this information. If you have any questions concerning this information, or our Notice of Privacy Practices, please contact our Privacy Official listed below. We thank you for updating our records and for your patronage.

Sincerely,

James Corkrean — James A. Corkrean, Rph

Sean Corkrean — Sean Corkrean Pharm.D.

I acknowledge that a copy of The Pharmacist's Notice of Privacy Practices has been made available to me

_____ **Patient's Printed Name**

_____ **Patient's Signature**

_____ **Date**

INDIVIDUAL(S) AUTHORIZED TO PICK-UP MY PRESCRIPTIONS: _____

ADDITIONALY: PHARMACIST JUDGEMENT AND VERBAL AUTHORIZATIONS APPLY.