Patient History Form

To be completed by the patient - required for first order only

Patient Information:

Name		Home Phone #	
Address		Home Fax #	
City		Email Address	
State		Sex	☐ M ☐ F
Zip Code		Birth Date:	
How did you hear about us?		Do you have any drug allergies?	☐ Yes ☐ No
If yes, please explain:			

Physician Information

Primary Physician Name		Phone #			
Address		Fax #			
City		State		Zip Code	

Please list all the medications you are currently taking, including Name, Strength, and Times per day.

Please indicate if you have never taken this medication before by placing an **"N"** before the name of the medication.

1		2	
3		4	
5		6	
7		8	
9		10	

Patient Medical History (Optional - filled out by patient)

1. Generic medications can be used if available? ☐ Yes ☐ No
2. Child resistant containers are mandatory in Manitoba where appropriate.
   If you do NOT want them, please check this box: ☐
3. When would you like a pharmacist to call you to discuss your medication? _____

Signature: _____ Date: _____

Mail: ThriftyMedsNow 408 Main St Box 490 Manitou, MB, Canada R0G 1G0
Phone (Toll Free): 1-866-999-7928 Fax (Toll Free): 1-866-292-7217

For office use only - Counselling completed. Date: _____