

First-time Users of Student Health Pharmacy

Last Name _____ First Name _____ Middle _____

Your University ID # _____ Date of Birth _____

Your Local Physical Address _____

E-mail Address _____

Your Local or Cell Phone # _____

Sex: Male or Female (circle one) _____ Tobacco user: Yes or No (circle one)

Do you have allergies to any medications? (Please list the medications.)

Are you currently taking any medications? (Please list the medications, include over-the-counter and herbal products.)

Do you have any medical conditions? (Please list.)
