**Grandparents Pharmacist intake form**

**Patient Information:**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Gender:** ☐ Male ☐ Female ☐ Other
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information:**

1. **Primary Care Physician:**
   * Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Current Medications:** (Include prescription, over-the-counter, herbal, alternative, vitamin, mineral)
3. **Allergies to medications:**
4. **Medical Conditions:**
5. **Current Symptoms/Concerns:**

**Lifestyle Information:**

1. **Dietary Preferences/Restrictions:**
2. **Physical Activity Level:**
   * ☐ Sedentary
   * ☐ Lightly active
   * ☐ Moderately active
   * ☐ Very active
3. **Social Support:**
   * Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Do you have regular visitors? ☐ Yes ☐ No

**Medication Management:**

1. **Do you have any difficulties with your medications?**  
   ☐ Yes ☐ No (If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)
2. **Do you use any medication management tools (e.g., pill organizers, reminders)?**  
   ☐ Yes ☐ No (If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Consultation Goals:**

* What specific concerns would you like to address during this consultation?

**Additional Comments or Questions:**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_