



RC Compounding Services
 3030 Center Road
 Poland, OH 44514
 P: (330) 707-9001
 E: info@rccompounding.com
 www.rccompounding.com



Want to fill out this form electronically? Scan the QRL code to the right and send the completed form to:
info@rccompounding.com



New Patient Intake Form

Patient's Last Name (Please Print)	First Name	Middle Initial	Area Code & Home Phone Number () - -	
Street Address			Email	
City, State & Zip Code			Gender	Birthday

Medical Information

<p>Allergies Please check all known allergies including symptoms experienced:</p> <p><u> </u> NO KNOWN ALLERGIES</p> <p><u> </u> Aspirin I experienced _____</p> <p><u> </u> Cephalosporins I experienced _____</p> <p><u> </u> Codeine I experienced _____</p> <p><u> </u> Erythromycin I experienced _____</p> <p><u> </u> Food Additive or Dyes I experienced _____</p> <p><u> </u> Penicillins I experienced _____</p> <p><u> </u> Ibuprofen I experienced _____</p> <p><u> </u> Morphine I experienced _____</p> <p><u> </u> Sulfa Drugs I experienced _____</p> <p><u> </u> Tetracyclines I experienced _____</p> <p>OTHER ALLERGIES AND DRUG REACTIONS: _____ _____ _____</p>	<p>Health Conditions Please check the health condition(s) that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Angina</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Glaucoma</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Heart Conditions</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Hypo-Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/> Blood Clotting Disorders</td> <td><input type="checkbox"/> Hyper-Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/> Blood Pressure, High</td> <td><input type="checkbox"/> Kidney Disorder</td> </tr> <tr> <td><input type="checkbox"/> Breast Feeding</td> <td><input type="checkbox"/> Liver Disorder</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Lung Conditions</td> </tr> <tr> <td><input type="checkbox"/> Cholesterol, High</td> <td><input type="checkbox"/> Migraine</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Depression</td> </tr> <tr> <td><input type="checkbox"/> Diabetes (Insulin Dependent)</td> <td><input type="checkbox"/> Parkinson's Disease</td> </tr> <tr> <td><input type="checkbox"/> Diabetes (Non-Insulin Dependent)</td> <td><input type="checkbox"/> Pregnancy</td> </tr> <tr> <td><input type="checkbox"/> Digestive Conditions</td> <td><input type="checkbox"/> Prostate Condition</td> </tr> <tr> <td><input type="checkbox"/> Other Health Conditions:</td> <td><input type="checkbox"/> Other Health Conditions:</td> </tr> </table> <p>_____ _____</p>	<input type="checkbox"/> Angina	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypo-Thyroid Condition	<input type="checkbox"/> Blood Clotting Disorders	<input type="checkbox"/> Hyper-Thyroid Condition	<input type="checkbox"/> Blood Pressure, High	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Breast Feeding	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung Conditions	<input type="checkbox"/> Cholesterol, High	<input type="checkbox"/> Migraine	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes (Insulin Dependent)	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Diabetes (Non-Insulin Dependent)	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Digestive Conditions	<input type="checkbox"/> Prostate Condition	<input type="checkbox"/> Other Health Conditions:	<input type="checkbox"/> Other Health Conditions:
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Prescription Information

Don't want to write down all of your medications? Send us pictures of your medication bottles at: info@rccompounding.com

Please complete your Profile by indicating any medications, non-prescriptions drugs, vitamins, and herbal products you use:

<p><u>Prescription Medications:</u> _____ _____ _____ _____ _____</p>	<p><u>OTC Medications:</u></p> <table border="0"> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> Pain Relievers</td> </tr> <tr> <td><input type="checkbox"/> Antacids</td> <td><input type="checkbox"/> Sleep Aids</td> </tr> <tr> <td><input type="checkbox"/> Caffeine</td> <td><input type="checkbox"/> Tobacco</td> </tr> <tr> <td><input type="checkbox"/> Cold/Allergy</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Laxatives</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Nasal Spray</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Pain Relievers	<input type="checkbox"/> Antacids	<input type="checkbox"/> Sleep Aids	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Cold/Allergy	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Laxatives	_____	<input type="checkbox"/> Nasal Spray	_____	<p><u>Vitamins/Herbal Supplements:</u></p> <table border="0"> <tr> <td><input type="checkbox"/> Vitamin A</td> <td><input type="checkbox"/> Multivitamin</td> </tr> <tr> <td><input type="checkbox"/> Vitamin B/C</td> <td><input type="checkbox"/> Minerals</td> </tr> <tr> <td><input type="checkbox"/> Vitamin D</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Calcium</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Garlic</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Iron</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Vitamin A	<input type="checkbox"/> Multivitamin	<input type="checkbox"/> Vitamin B/C	<input type="checkbox"/> Minerals	<input type="checkbox"/> Vitamin D	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Calcium	_____	<input type="checkbox"/> Garlic	_____	<input type="checkbox"/> Iron	_____
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All of the above information is accurate and I understand I will notify RC Compounding Services about any changes in my medications, OTC medications, vitamins/health supplements, and health conditions. I understand I have the right to receive consultation from a registered pharmacist.

Signature: _____

Date: _____