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

Allergies

Please check all known allergies including symptoms experienced:

___**NO KNOWN ALLERGIES**

___Aspirin I experienced______________________________

___Cephalosporins I experienced______________________________

___Codeine I experienced______________________________

___Erythromycin I experienced______________________________

___Food Additive or Dyes I experienced______________________________

___Penicillins I experienced______________________________

___Ibuprofen I experienced______________________________

___Morphine I experienced______________________________

___Sulfa Drugs I experienced______________________________

___Tetracyclines I experienced______________________________

OTHER ALLERGIES AND DRUG REACTIONS:

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Health Conditions

Please check the health condition(s) that apply:

- ☐ Angina
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clotting Disorders
- ☐ Blood Pressure, High
- ☐ Breast Feeding
- ☐ Cancer
- ☐ Cholesterol, High
- ☐ Depression
- ☐ Diabetes (Insulin Dependent)
- ☐ Diabetes (Non-Insulin Dependent)
- ☐ Digestive Conditions
- ☐ Other Health Conditions:

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- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Hypo-Thyroid Condition
- ☐ Hyper-Thyroid Condition
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Conditions
- ☐ Migraine
- ☐ Depression
- ☐ Parkinson's Disease
- ☐ Pregnancy
- ☐ Prostate Condition
- ☐ 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:

Prescription Medications:

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OTC Medications:

- ☐ Alcohol
- ☐ Antacids
- ☐ Caffeine
- ☐ Cold/Allergy
- ☐ Laxatives
- ☐ Nasal Spray
- ☐ Pain Relievers
- ☐ Sleep Aids
- ☐ Tobacco
- ☐ Other:

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Vitamins/Herbal Supplements:

- ☐ Vitamin A
- ☐ Vitamin B/C
- ☐ Vitamin D
- ☐ Calcium
- ☐ Garlic
- ☐ Iron
- ☐ Multivitamin
- ☐ Minerals
- ☐ Other:

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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:** _________________________

Pharmacy Use Only: RPh Reviewed: __________ Patient Info Added: __________ Patient Contacted: __________