ST. PAUL CORNER DRUG
Pharmacy the way it should be. est. 1922
240 South Snelling Avenue ~ St. Paul, MN 55105
Phone 651 698-8859 Fax 651 698-0005

Confidential New Patient Intake Form

Full Name: _____DOB: _____/_____/_____ Gender: M F

Social Security # (last 4 digits) XXX-XX-_____

Address: _____Telephone: (_____) _____-_____ H W Cell

City: _____ ST:_____ Zip:_____Alt Phone: (_____) _____-_____ H W Cell

Email: _____Used for pharmacy-related communication only

Health History

Allergies/Adverse Reactions:_____

_____

***Please include reaction to each (hives, stomach upset, anaphylaxis, etc.)**

Primary Doctor: _____

Please check "Yes" or "No" for each of the following to indicate whether or not the following conditions apply to you:

Yes	No		Yes	No	
□	□	High Cholesterol	□	□	Hyperthyroidism
□	□	High Blood Pressure	□	□	Hypothyroidism
□	□	Diabetes **Type**: I or II	□	□	Anxiety
□	□	Environmental Allergies	□	□	Depression
□	□	Asthma	□	□	Migraine/Headache
□	□	ADD/ADHD	□	□	Epilepsy
□	□	Acid Reflux /GERD	□	□	Pacemaker
□	□	Glaucoma	□	□	Pregnant
□	□	Colitis/Crohn's Disease	□	□	Nursing
□	□	Renal Disease	□	□	**Other:**_____
□	□	Arthritis	□	□	**Easy-open Rx bottle caps?**

Please list any medications (prescription and over the counter) that you are currently taking.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please include a copy of your current insurance card(s)