

HEALTH CARE INFORMATION  
(REQUIRED TEXAS REGULATIONS EFFECTIVE 1/93)  
Owens-Franklin Health Center

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Last Name      First Name      Middle Initial      Sex      Date of Birth

**Local:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
          Area Code    Phone      Address      City      State      Zip

**Permanent:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
          Area Code    Phone      Address      City      State      Zip

**CHECK ALL THAT APPLY**

**Drug Allergies /Reactions**

No Known Allergies

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Angina                | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Cephalosporins (ex.Keflex) |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Conditions      | <input type="checkbox"/> Codeine                  | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Erythromycin          | <input type="checkbox"/> Blood Clotting Disorders | <input type="checkbox"/> Lung Disease               |
| <input type="checkbox"/> Sulfa Drugs    | <input type="checkbox"/> Blood Pressure (high) | <input type="checkbox"/> Parkinson's disease      | <input type="checkbox"/> Tetracycline's             |
| <input type="checkbox"/> Breast Feeding | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Penicillin     | <input type="checkbox"/> Other _____           |   |   |

Please list medications(s) currently being taken that was not filled at this pharmacy.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Please list non-prescription medicine taken on a regular basis.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Other information you feel important for the pharmacist to know: \_\_\_\_\_  
\_\_\_\_\_

Please initial here if you have no information to fill in the above spaces. \_\_\_\_\_

Unless otherwise specified by you or your physician, your pharmacist may dispense (when available a product that is therapeutically and generically equivalent to the brand prescribed. The intent of this state regulation is to save consumers money. Use generic drugs when available:  Yes  No

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ALL INFORMATION PROVIDED BY YOU IS KEPT CONFIDENTIAL**