RUTGERS
UNIVERSITY | NEW BRUNSWICK

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Student Health
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RSH PHARMACY SERVICES
PATIENT INFORMATION FORM

Please complete this form and return it with your prescription. All information will be held in the strictest confidence. **PLEASE PRINT CLEARLY**. Thank you.

NAME: ____

RESIDENCE HALL NAME & ROOM # (OR OFF CAMPUS ADDRESS): __________________________________

SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH: _______________________

STUDENT ID # _________________________ PHONE # ____________________________

DO YOU HAVE ANY FOOD/DRUG ALLERGIES?

☐ YES ☐ NO

IF YES, PLEASE LIST BELOW

____

____

____

____

DO YOU HAVE ANY CHRONIC CONDITIONS?

☐ YES ☐ NO

IF YES, PLEASE CHECK THOSE THAT APPLY:

☐ ASTHMA ☐ DIABETES

☐ GLAUCOMA ☐ HEART CONDITION

☐ IBS ☐ HIGH BLOOD PRESSURE

☐ OTHER: ________________________

ARE YOU TAKING ANY KIND OF MEDICATION, BIRTH CONTROL, AND/OR INSULIN AT THE PRESENT TIME?

☐ YES ☐ NO

IF YES, PLEASE LIST: ____

HOME ADDRESS AND PHONE NUMBER FOR OUT CONFIDENTIAL FILE (IF DIFFERENT FROM ABOVE):

ADDRESS: _______________________________________PHONE # ______________________

CITY: ___________________________________STATE: __________ ZIP CODE: _____________

Updated: July 2018