



PATIENT HEALTH HISTORY FORM

Patient Information	
First & Last Name:	Date of Birth (MM/DD/YYYY):
Primary Address:	Secondary Address (Optional):
Preferred phone: () <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home	Alternative phone: () <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home
Emergency Contact Information	
Emergency Contact Name:	Relationship to Patient:
Emergency Contact Phone: () <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home	Privacy Notes (<i>optional</i>):
Check the box if you do not want to add an emergency contact. <input type="checkbox"/> <i>By checking the box, I decline to add an emergency contact to my patient profile.</i>	
Patient Health Information	
Weight (in pounds):	Height:
Are you pregnant, nursing or planning pregnancy (check one)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Other health conditions:	
Allergies and Reaction (ex. Sulfa Medication Allergy with Hives):	



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Current Medications (include over-the-counter drugs and herbal supplements)					
Medication name	Date you started taking medication	Frequency	Dose	Route (oral, inhaled, injection, etc.)	Condition for which medication is prescribed

Please fax or mail completed form to:

Costco Specialty Pharmacy
310 Integrity Drive, Ste. 105
Madison, WI 53717
Fax: 855-847-3558