ACS Advanced Care Scripts

Patient Medication Profile

Name: ____________________________ Date of Birth: ____________________

☐ Male
☐ Female

Weight ____________
Height ____________

List medical conditions:

Drug Allergies

Please check all that apply

☐ None	☐ Compazine	☐ Percocet
☐ Amoxicillin	☐ Darvocet	☐ Phenobarbital
☐ Ampicillin	☐ Darvon	☐ Opiates
☐ Aspirin	☐ Demerol	☐ Septra
☐ Bactrim	☐ Epinephrine	☐ Sulfa
☐ Biaxin	☐ Ibuprofen	☐ Talwin
☐ Ceclor	☐ Keflex	☐ Tetracycline
☐ Cipro	☐ Penicillin	☐ Tylenol
☐ Codeine	☐ Percodan	☐ Valium
Other: ____________	Other: ____________	Other: ____________

Current Medications

Please list all medications you are currently taking, including over the counter products and those provided by another pharmacy. This list will only be used to identify drug interactions.

☐ Check this box if you are only taking the drug provided by ACS
I prefer to not provide ACS with a list of my current medications.

1. ____________	7. ____________	13. ____________
2. ____________	8. ____________	14. ____________
3. ____________	9. ____________	15. ____________
4. ____________	10. ____________	16. ____________
5. ____________	11. ____________	17. ____________
6. ____________	12. ____________	18. ____________

Signature: ______________________________ Date Completed____________________

Clinical Counseling is available from certified medical professionals during ACS hours of operation. Please feel free to contact one of our Registered Nurses or Pharmacists toll free at 877-985-MEDS (6337). Fax: 866-679-7131

There are also resources available at our website: www.advancedcarescripts.com