



**Medical History:**

**Current primary care physician:**

**Medical diagnoses:**

**Current medication list (please attach if needed):**

**Allergies to medication:**

**Family history of mental illness:**

**Social history:**

**What year are you in school?**

**Are you working?**

**Who do you live with (family, friends, roommate, alone)?**

**What are your hobbies/interests?**

**Pharmacy Name and Location:**

**Pharmacy Phone Number:**

---

**Signature**

---

**Date**