VASHON
PHARMACY

Clinical Intake Form

NAME:_____ Date of Birth:_____

Phone:_____ I authorize the pharmacy to text me at this number ⬜

Physical Address:_____ EMAIL:_____

_____

Medical Insurance Information:

Insurance Provider: _____ Insured Person: Self or Other _____

Plan#_____ ID#_____

Primary Care Doctor/Phone Number (if available): _____

Demographic Information:

Race:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Prefer not to answer

Sex assigned at Birth?

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer

Are you Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

Are you currently pregnant?

- ☐ Yes
- ☐ No

(continue on next page)

APPOINTMENT DETAILS:

What is your concern today? (cough, side effect, blood pressure, etc..)

_____

_____

Medical Conditions:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Failure
- ☐ COPD
- ☐ Cancer
- ☐ Autoimmune Disease
- ☐ Thyroid Dysfunction
- ☐ IBS or Crohn's
- ☐ Other (please list): _____

Please list any allergies:

_____

Please list any medications you take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Immunization History (check all you recall having):

- ☐ Seasonal Flu
- ☐ Tetanus/TdaP
- ☐ Covid
- ☐ Pneumonia
- ☐ Shingles
- ☐ Hepatitis B
- ☐ Gardisil (Hpv)
- ☐ Other:_____ _____

Payment Preference

- ☐ $150 - Fee for service - my insurance will not be billed - I will pay today
- ☐ I have provided my insurance information above, I will be charged my copay as designated by my plan and any additional fees based on insurance coverage will be my responsibility.

Name + Signature: _____/_____ Date: _____