Blanchfield Pharmacy Assisted Self-Care Screening Form

Patient Name:	Sponsor last 4/DoD IEN:
DOB (& Age if under 12yo):	Weight (if under 12yo):
Med Allergies/Adverse rxns:	Pregnant: Y N n/a Breastfeeding: Y N n/a

Health Conditions (Circle all applicable)		
High Blood pressure	Glaucoma	Heart disease
Thyroid disorder	Diabetes	Asthma
Benign Prostatic Hyerplasia (BPH)	Emphysema	Bronchitis

Current Symptoms (Circle all applicable)		
COUGH	FEVER/PAIN	ALLERGIES
CONGESTION (chest or nasal)	UPSET STOMACH/ GAS/NAUSEA	DIARRHEA/ CONSTIPATION
YEAST INFECTION	HEARTBURN/ REFLUX	LICE
SKIN IRRITATION	CONDOMS/ PLAN B	VITAMINS

How long have you had these symptoms?	
What else have you tried for this illness?	

Place Dispensed Rx Label(s) Here

Prepared: 2019 12 17