

Women's International Pharmacy recognizes the importance of keeping your information up to date so that our staff can provide you the best quality service and care. Please complete this form and return it at your earliest convenience. This form is also available online at [womensinternational.com](http://womensinternational.com). Be assured that this information will remain confidential.

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Driver's License #: (Required by law in some states) \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

(Work): \_\_\_\_\_

Email Address: \_\_\_\_\_

## Health Information

Please provide the following information to ensure quality service and care.

Allergies: \_\_\_\_\_

\_\_\_\_\_

Conditions (e.g., Heart Disease, Diabetes, etc.): \_\_\_\_\_

\_\_\_\_\_

Other Medications and/or Supplements: \_\_\_\_\_

\_\_\_\_\_

## Non-Safety Cap Option

Women's International Pharmacy requires a signature to have non-safety caps placed directly on all of your prescription vial(s).

*(You may change your mind about the use of such packaging at any time.*

*Please contact the pharmacy should your packaging preference change.)*

Yes, I would like a non-safety cap placed on ALL of my prescription vials.

Your signature: \_\_\_\_\_ Date \_\_\_\_\_