

Order Number: _____

First Name: _____ **Last Name:** _____

Medical Questionnaire

Our doctor may need to review your medical condition. Please answer the following questions:

Your Gender: Male Female
Date of Birth: (MM/DD/YYYY) (/ /)
Your Weight and Height: (/ lb/ in)(/ kg/cm)

Please list known drug allergies:

Please list all medications you are currently taking:

Do you take any form of nitroglycerine? Yes No

Your primary Physician's name: Dr:
Physician's phone number: () -

This information is for your own safety. Discount Pharmacy.biz will not contact your doctor. All information provided to Discount Pharmacy.biz will be kept confidential.