

Personal Profile Please return all forms including your prescriptions via fax, email or mail.

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Gender: Male Female Weight: _____Lbs. Age: _____ Date of Birth (M/D/Y): ____ / ____ / ____

Occupation: _____

Physician Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ License #: _____

Physician Information

Check the box if you have had a physical examination in the last 12 months. Yes

Family Medical History (check only those that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes, Thyroid or other endocrine disorder | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Lipid (cholesterol) Disorder |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Cardiovascular (heart or artery disease) | <input type="checkbox"/> Other forms of Cancer | |

Patient Medical History (check only those that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Poor or slow healing of wounds | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Edema or excessive fluid retention | <input type="checkbox"/> Renal or Kidney disease | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Thyroid, diabetes or other endocrine disorder (including Insulin resistance) | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Emotional disorders |
| <input type="checkbox"/> Any known nutrition deficiency (Including minerals and electrolytes) | <input type="checkbox"/> Hyperlipidemia (high cholesterol) | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Upper Respiratory Disorder | <input type="checkbox"/> Orthopedic or muscle disorder (including fracture, joint disorder or carpal tunnel syndrome) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Lung disorder (i.e.: asthma, emphysema) | <input type="checkbox"/> Connective tissue disorder | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Heart disease (including arteriosclerosis, angina, heart failure or history of) | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Lupus |
| | | <input type="checkbox"/> Regular exercise |
| | | <input type="checkbox"/> Other illness not noted |

If you answered yes to any of the above questions, please elaborate below: (i.e. duration of illness, any treatment of surgery received, amount smoked and how long): _____

I will accept generic name alternatives instead of brand name where possible: Yes No

I want my medication bottles supplied with safety caps: Yes No

By choosing No, I accept full responsibility for protecting my medication against loss, damage or abuse by any other party.

I would like to have patient counseling in the fulfillment of this prescription order: Yes No

If you request patient counseling, we will inform you about the prescription we provide. Patient counseling will be conducted in an atmosphere of confidentiality and privacy. This information includes the drug name, what it does, how and when it should be taken, the importance of taking the drug as prescribed, what to do if a dose is missed, common side effects, food and other drugs to avoid and storage requirements.

Current Medication

| Medication | Strength | Quantity | Direction for Use | Medical Condition |
|------------|----------|----------|-------------------|-------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list any allergies: _____

Please choose the method of payment:

I authorize **Canadian Prescription Drugs Inc.** to bill my medication expenses to my:

- Visa
- MasterCard
- Discover card

Credit Card # _____ Expiry Date(M/Y) _____ / _____

Name of Cardholder _____

- Enclosed is a Cashier's Check/International Money Order for the amount of medication(s) plus shipping/handling & insurance.

Purchase and Return Agreement:

I understand and agree that I cannot return any medications delivered by **Canadian Prescription Drugs Inc.**

My doctor has prescribed this medication and it is for my personal use only.

To confirm that all the information above is true please sign below:

Customer Name (Print Clearly) Customer Signature Date(M/D/Y)

Help us improve our services. If you have any comments, please let us know.

How did you hear about us? _____

When did you hear about us? _____

What made you decide to order with us? _____