Lehan Drugs

We're more than medicine.

Patient Information Questionnaire

Please answer the following questions to help us create an accurate patient profile.
The questions marked with an * are required. If you have any questions,
the pharmacy staff would be happy to help.

Patient Information*

Name:		Birthday:	
Address:		City, State and Zip Code:	
Phone Number:		Cell Number:	
Allergies:		E-Mail:	

Primary Physician Information*

Physician Name:	
Physician Address:	
Physician's Phone Number:	

Do you fill prescriptions at a pharmacy other than Lehan Drugs?*

☐ Yes ☐ No

If yes, what other pharmacies (mail order, chain store, specialty. etc.) do you use to fill prescriptions?
What prescription medications do you have filled at these pharmacies? If no, and Lehans fills your medications then you can skip the "Prescription Medications" section

Pharmacy Name	Drug	Dose	Directions
Example: CVS	*Lisinopril*	*5 mg*	*Take one tablet by mouth daily*

Would you like child-resistant caps? Yes No

Would you like information about our Pill-pack service? Yes No

Would you like information about our vaccination program? Yes No (Are you current on vaccinations?)

Lehan Drugs offers a Sync and Adherence program, which assists patients in taking their medications on a regular basis. This program also coordinates a patient's prescriptions so that all medications can be picked up at the same time. Would you be interested in participating in this program? Yes No

Are you interested in receiving a notification when your prescriptions are ready to be refilled? Yes No
What is your preference? Email Text Phone
Are you interested in receiving a notification when your prescriptions are ready to be picked up? Yes No
What is your preference? Email Text Phone
Please select your preferred method of receiving prescriptions.*

☐ Pick-up at Lehan Drugs ☐ Home Delivery ☐ Call to coordinate

How would you prefer to be contacted by Lehan Drugs staff members?*

☐ Text Message ☐ E-Mail ☐ Phone

Prescription Medications*(skip this section if you get your prescriptions filled at Lehans)

Drug	Dose	Directions
Example: Simvastatin	*20 mg*	*One tablet by mouth at bedtime*

Over-the-Counter Medications*

Drug	Dose	Directions
Example: Tylenol Extra Strength	*500 mg*	*One tablet by mouth twice a day as needed for headaches*