

Pharmacy Service Record Form

Date: Year Month Day

Location:

Pharmacist:

General Information	Name		Gender		Age		Weight	
	Ethnicity		Occupation		Contact Information			
	Attending Physician				Insurance Type	☐ Urban Employee ☐ Urban Resident ☐ NRCMS ☐ Self-pay		
	Family History	☐ No ☐ Yes _____						
Patient Concerns or Special Needs								
History of Present Illness	Disease	Test Results			Test Date	Notes		
	☐ Hypertension	SBP: DBP:						
	☐ Diabetes	FBG: PBG: HbA1c:						
	☐ Hyperlipidemia	TC: TG:						
	☐ Coronary Heart Disease	LDL-C : HDL-C:						
	☐ Stroke							
	☐ Other: _____							
Past Medical History	Hospitalization: ☐ No ☐ Yes Reason: _____ MACE Occurrence: ☐ No ☐ Yes Description: _____					Hospitalized in Luohu Hospital Group: ☐ No ☐ Yes		
Allergy History:	☐ No ☐ Yes Suspected drug/food: _____							
Current Medications	Drug Name	Dosage/Duration			Adjustment Recommendation			

Adverse Drug Reactions	Frequency: _____ Suspected Drug: _____ Main Clinical Symptoms: _____ Management Outcome: ☐ Continued ☐ Relieved after discontinuation ☐ Relieved after treatment ☐ Not relievedn ☐ Not used again ☐ recurred after the second use Analysis: _____		
Medication Log	Issues: _____		
Drug Therapy Evaluation and Issues	<table border="1"> <tr> <td>Cause of unreasonability</td> <td>Suggestion</td> </tr> </table>	Cause of unreasonability	Suggestion
	Cause of unreasonability	Suggestion	
Indication: _____ Effectiveness: _____ Safety: _____ Adherence: _____			
Medication Education			
Lifestyle Assessment	Smoking	☐ Never ☐ Quit ☐ Current (Years: ____; Cigarettes/day: ____)	
	Alcohol	☐ Never ☐ Quit ☐ Current (Frequency/Amount: ____)	
	Diet	Preference: ☐ Meat ☐ Vegetarian ☐ Balanced Taste: ☐ Light ☐ Moderate ☐ Oily ☐ Salty ☐ Sweet	
	Exercise:	☐ None ☐ Occasional ☐ ≥1/week ☐ Almost daily	
	Sleep Quality:	☐ Good ☐ Fair ☐ Poor	
	Anxiety:	☐ None ☐ Mild ☐ Moderate ☐ Severe	
Lifestyle Recommendations:			

Follow-up Plan:	
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