CANADIAN PRESCRIPTION DRUGS, INC.
Real people helping real people.

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):

- ☐ Diabetes, Thyroid or other endocrine disorder
- ☐ Hypertension (high blood pressure)
- ☐ Cardiovascular (heart or artery disease)
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Other forms of Cancer
- ☐ Lipid (cholesterol) Disorder
- ☐ Migraine headaches

Patient Medical History (check only those that apply):

- ☐ Blood disorders
- ☐ Poor or slow healing of wounds
- ☐ Edema or excessive fluid retention
- ☐ Thyroid, diabetes or other endocrine disorder (including Insulin resistance)
- ☐ Any known nutrition deficiency (Including minerals and electrolytes)
- ☐ Upper Respiratory Disorder
- ☐ Lung disorder (i.e.: asthma, emphysema)
- ☐ Heart disease (including arteriosclerosis, angina, heart failure or history of)
- ☐ Cancer
- ☐ High blood pressure
- ☐ Renal or Kidney disease
- ☐ Liver disease
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Orthopedic or muscle disorder (including fracture, joint disorder or carpal tunnel syndrome)
- ☐ Connective tissue disorder
- ☐ Rheumatoid Arthritis
- ☐ Neurological disorders
- ☐ Immune disorders
- ☐ Smoke
- ☐ Emotional disorders
- ☐ Surgery
- ☐ Glaucoma
- ☐ Chemical dependency
- ☐ Lupus
- ☐ Regular exercise
- ☐ 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?____