Gulf States Pharmacy
A Service of Gulf States Hemophilia & Thrombophilia Center
6655 Travis St, Suite 490
Houston, TX 77030
(713) 500-8385 (800) 464-1440

PATIENT PROFILE

This request is required by state regulations so that we can provide appropriate pharmacy services to you. This information will be kept confidential.

Patient Name:
(Last)_____(First)_____(Middle)_____ Date of Birth _____

Mailing address: _____ City: _____ State:_____ Zip:_____

Home phone: _____ Work: _____ Cell: _____ E-mail:_____

If minor, Caregiver's name _____ Language preference on Labels (circle one): English or Spanish

Shipping Address (if different from above) _____

City: _____ State: _____Zip:_____ Phone: _____

Primary Medical Conditions:
☐ Hemophilia A (circle one: severe, moderate, mild, carrier)
☐ Hemophilia B (circle one: severe, moderate, mild, carrier)
☐ Von Willebrand's Disease (type _____)
☐ Other Bleeding Disorder—specify _____

Gender: M or F Height _____Weight _____
Drug allergies: _____
_____
Other allergies: _____
_____

Do/Did you have an inhibitor? Yes or No When? _____ Do you have a Port? Yes or No

Other Medical conditions: _____
_____

Please list all medications (including over the counter meds) currently taking:

Start	Stop date	Medication	Dose	Route	Frequency	Reason

Other information you want us to know or any special requests: _____
_____
_____

Please notify Gulf States Pharmacy of any changes to medications, allergies, health conditions, drug reactions.

Signature _____Relationship to Patient (if not patient)_____ Date_____