



## Section B - Optional Information

Completion of this section is optional, but the information provided will allow us to provide you with a better service. If you are not the patient, please obtain their permission before providing information on their behalf. This information will be held securely in our pharmacy's patient records system. When you use the service again you will not need to provide all the information again - only those things that have changed.

**Have this information been provided previously?**

Yes - no changes	tick <input type="checkbox"/>
Yes - see changes below	<input type="checkbox"/>
No	<input type="checkbox"/>

**Patient's Medical Conditions and Allergies:**

Please tick any of the following conditions which apply to the patient:

	tick		tick		tick
Angina	<input type="checkbox"/>	Gastric Ulcer	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Bronchitis/Emphysema	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>
Crohns Disease	<input type="checkbox"/>	Heart Arrhythmia	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Hypercholesterolaemia	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	Trigeminal Neuralgia	<input type="checkbox"/>

**Does the patient have any other medical conditions or allergies (e.g. to foods or medicines) not included in the above list? If so please tell us about them**

**Is the patient pregnant?** Yes  No  Don't know

**Is the patient breast feeding?** Yes  No

**Does the patient have difficulty opening child resistant container:** Yes  No

**Have you ever used this service before?** Yes  No

**Have you already registered with the boots.com website?** Yes  No

**Do you usually get your prescribed medication from Boots?** Yes  No

**In future, would you like Boots to send you information about conditions you may have and on living a healthy active life?** Yes  No

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The information provided in this form will remain confidential . Only authorised Boots staff will have access to it. We will only share this information with your permission, or where we are legally obliged to do so

**Please allow 5 working days from posting your prescription before delivery.**

**Please be aware that you will need to be available to sign for receipt of the medicines**

**We will e-mail you the day we despatch your order**

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