

Health, Allergy & Medication Questionnaire



Your privacy is important to us. We comply with federal privacy regulations. Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each family member enrolled in your pharmacy benefit plan.
- If you need additional forms you may call Member Services at the toll-free number listed on your ID card.
- **Return this questionnaire with your prescription or refill order form.**

SECTION 1

MEMBER IDENTIFICATION AND CONTACT

<input type="text" value="AVMEDMD"/>	<input type="text" value="XXXXXX"/>	<input type="text" value="XX-XX-XXXX"/>
Group Number	Member Number	Daytime Telephone Number
<input type="text" value="XXXXXX"/>	<input type="text" value=""/>	<input type="text" value="XXXXXXXXXXXX"/>
Primary Member: First Name	M.I.	Last Name

Street Address/Apt. No.	City	State	Zip
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SECTION 2

DRUG ALLERGY CONDITIONS

For each family member enrolled in the program, include his/her name, date of birth and gender. For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If you are allergic to a medication that is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: Please use blue or black ink.

	Enrollee	Spouse	Dependent	Dependent	Dependent
First Name: Add last name if different than enrollee					
Date of Birth:					
Gender:	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F
Penicillins/cephalosporins (e.g. ampicillin, Keflex®)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tetracycline antibiotics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin, Biaxin®, Zithromax®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine (e.g. Tylenol #3®)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aspirin (salicylates)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sulfa medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Iodine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print other medication allergies not listed above in the space provided. Example: <i>morphine</i>					



Continue on the other side to tell us about any medical conditions.

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said **that particular family member** has the condition.

First Name:	Enrollee	Spouse	Dependent	Dependent	Dependent
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies, runny nose, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood sugar (diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic, stomach, or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High pressure in the eyes (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation in the legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with blood not clotting properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Print other medical conditions not listed above in the space provided. Example: <i>glaucoma</i>					

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank You

