

Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. We comply with federal privacy regulations and will protect this information.

Follow the steps listed below.

Step 1: Verify and complete information in SECTION 1.

Step 2: Complete all sections below using blue or black ink. Please print.

Step 3: Return the completed questionnaire in the self-addressed envelope with your mail-order form or refills. If you do not have a preaddressed envelope, please return the questionnaire to:

Medco Health Solutions, Inc.
 4865 Dixie Highway
 Fairfield, OH 45014
 Attn: HMQ

SECTION 1: Patient information

Patient name: _____ Gender: _____

Month/Year of birth: _____ Contact phone:

Patient member number: _____

(Located on your ID card.)

SECTION 2: Your medication allergies

Fill in the oval **completely** if you have had an allergy or serious reaction to any of these medications:

<input type="radio"/>	Aspirin and salicylates (for example: ZORprin [®] , Trilisate [®])
<input type="radio"/>	Codeine (for example: Tylenol [®] #3)
<input type="radio"/>	Erythromycin, Biaxin [®] , Zithromax [®]
<input type="radio"/>	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil [®] , Motrin [®])
<input type="radio"/>	Penicillins/cephalosporins (for example: Amoxil [®] , amoxicillin, ampicillin, Keflex [®] , cephalexin)
<input type="radio"/>	Sulfa drugs (for example: Septra [®] , Bactrim [®] , TMP/SMX)
<input type="radio"/>	Tetracycline antibiotics
If you have an allergy to a medication that is not listed above, print the name of that medication in the space below. Example: morphine	
other:	
other:	

(over, please)

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

<input type="radio"/>	Allergies, hay fever (allergic rhinitis)	<input type="radio"/>	Heart failure (CHF)
<input type="radio"/>	Arthritis	<input type="radio"/>	Hemophilia and hemophilia-like conditions
<input type="radio"/>	Asthma	<input type="radio"/>	High blood pressure (hypertension)
<input type="radio"/>	Bladder control problem (urinary incontinence)	<input type="radio"/>	High blood sugar (diabetes)
<input type="radio"/>	Brittle bones (osteoporosis)	<input type="radio"/>	High cholesterol (hypercholesterolemia)
<input type="radio"/>	Chest pain (angina)	<input type="radio"/>	Inflammatory bowel disease
<input type="radio"/>	Crohn's disease	<input type="radio"/>	Migraine headache
<input type="radio"/>	Depression	<input type="radio"/>	Overactive thyroid (hyperthyroid)
<input type="radio"/>	Emphysema (COPD, chronic bronchitis)	<input type="radio"/>	Peptic, stomach, or duodenal ulcer
<input type="radio"/>	Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	Poor circulation in the legs (peripheral vascular disease)
<input type="radio"/>	Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	Seizures (epilepsy)
<input type="radio"/>	Glaucoma	<input type="radio"/>	Stroke (TIA)
<input type="radio"/>	Heart attack (myocardial infarction)	<input type="radio"/>	Underactive thyroid (hypothyroid)

If you have a medical condition that is not listed above, print the name of that medical condition in the space below. Example: breast cancer

other:

other:

SECTION 4: Your nonprescription medications

Fill in the oval completely for each nonprescription medication that you are currently taking on a regular basis.

<input type="radio"/>	Advil [®] /ibuprofen	<input type="radio"/>	Prilosec OTC [®] /omeprazole
<input type="radio"/>	Aleve [®] /naproxen	<input type="radio"/>	Sominex [®] , Nytol [®] /diphenhydramine
<input type="radio"/>	Bayer [®] /aspirin	<input type="radio"/>	Tagamet [®] /cimetidine
<input type="radio"/>	Benadryl [®] /diphenhydramine	<input type="radio"/>	Tylenol [®] /acetaminophen
<input type="radio"/>	Orudis KT [®] /ketoprofen	<input type="radio"/>	Zantac [®] /ranitidine
<input type="radio"/>	Pepcid AC [®] /famotidine		

If you take a nonprescription medication that is not listed above, print the name of that medication in the space below.

other:

other:

SECTION 5: Patient prescription medications*

Please list the **prescription medications** you are currently taking in the space below. *Information can be found on the prescription labels. If none, please check here. [] NONE

Did you complete both sides?

Thank you very much.

