EXPRESS SCRIPTS®

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. Express Scripts complies 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:

Express Scripts
P.O. Box 14395
Lexington, KY 40512

SECTION 1: Patient information

Patient name: _____ Gender: _____

Month/Year of birth: _____ Contact phone: | | | | | | | | | | |

Patient member number: _____ Group: _____

(Located on your member ID card and/or in your benefit information.)

SECTION 2: Your medication allergies

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

○	Aspirin and salicylates (for example: ZORprin®, Trilisate®)
○	Codeine (for example: Tylenol® #3)
○	Erythromycin, Biaxin®, Zithromax®
○	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil®, Motrin®)
○	Penicillins/cephalosporins (for example: Amoxil®, amoxicillin, ampicillin, Keflex®, cephalexin)
○	Sulfa drugs (for example: Septra®, Bactrim®, TMP/SMX)
○	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.

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

○	Advil®/ibuprofen	○	Prilosec OTC®/omeprazole
○	Aleve®/naproxen	○	Sominex®, Nytol®/diphenhydramine
○	Bayer®/aspirin	○	Tagamet®/cimetidine
○	Benadryl®/diphenhydramine	○	Tylenol®/acetaminophen
○	Orudis KT®/ketoprofen	○	Zantac®/ranitidine
○	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.**