EXPRESS SCRIPTS®

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. Complete and return this form following the steps below or go to Express-Scripts.com/healthform to submit it online:

Step 1: Verify and complete information in SECTION 1.

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

FOLD HERE

SECTION 1: Patient information

Patient name: *(First name, Last name)*

Gender: Male ○ Female ○

Date of Birth: *Month* *Day* *Year*

Contact phone:

Member number:
(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

FOLD HERE

SECTION 3: Your medical supplies and equipment

Fill in the oval **completely for each medical supply or therapy that you use on a regular basis.**

○	Diabetes test strips	○	Catheters and accessories
○	Insulin pumps	○	Sleep apnea supplies
○	Ostomy bags	○	Erectile dysfunction equipment

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		

(over, please)

Patient name: **Date of birth:** Month Day Year

SECTION 5: 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)

Additional health information

If you have any other medication allergies, medical conditions, prescription medications not filled under your pharmacy benefit, or nonprescription medications not listed above, please call 877.438.4417.

End of Express Scripts Health, Allergy & Medication Questionnaire

Information Sharing Authorization

I hereby authorize Express Scripts to disclose to its subsidiaries and affiliates my health information in its entirety for the purpose of providing me with educational, informational, and promotional communications specific to my health. This authorization will be effective for five (5) years from the date this form is processed by Express Scripts and may be revoked by me at any time by submitting a letter in writing to Express Scripts, 4865 Dixie Highway, Fairfield, OH 45014. I understand that if I revoke this authorization it will not affect any action that Express Scripts may have taken prior to Express Scripts' receipt of the written notice of revocation. I understand that I will still be eligible for the same health plan benefits from Express Scripts whether or not I authorize information sharing. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any other health information privacy laws. I affirm that the signature below is mine and that I am authorizing for myself or my minor dependent child named below.

Patient name:

Signature _____

Did you complete both sides?

Thank you very much.

Place your completed questionnaire in the envelope marked HMQ. Do not send prescriptions, refill slips, or correspondence with this questionnaire. Be sure the address shows through the window.

HMQ PROCESSING CENTER
PO BOX 14238
LEXINGTON, KY 40512-4238