Health, Allergy & Medication Questionnaire

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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 the Empire plan.
- If you need additional forms you may call 1 877-7NYSHIP (1 877-769-7447), Option 4.
- **Return this questionnaire with your prescription or refill order form.**

SECTION 1 **ENROLLEE IDENTIFICATION AND CONTACT**

UH0712959
Group Number

Enrollee ID Number

Daytime Telephone Number ___ - ___ - ____

Primary Enrollee: First Name **M.I.** **Last Name**

Street Address/Apt. No. **City** **State** **Zip**

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:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillins/cephalosporins (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	○	○	○	○	○
Aspirin (salicylates)	○	○	○	○	○
Sulfa medications	○	○	○	○	○
Iodine	○	○	○	○	○
Print other medication allergies not listed above in the space provided.					

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

SECTION 3 **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	○	○	○	○	○
High blood pressure	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine headache	○	○	○	○	○
Print other medical conditions not listed above in the space provided.					

Did you complete both sides?

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

Thank You