



**Section 4: Drug Allergy Conditions.** Please fill in the circle **ONLY** if you have had an allergy or bad reaction to this medication in the past. If you have had an allergy to a medication not listed below, please print the name of that medication in the blank spaces at the bottom of this section.

Penicillins/cephalosporins	Such as <i>Amoxil</i> <sup>®</sup> , amoxicillin, ampicillin, <i>Ceclor</i> <sup>®</sup> , <i>Ceftin</i> <sup>®</sup> , <i>Keflex</i> <sup>®</sup> , cephalexin	<input type="radio"/>
Tetracycline antibiotics		<input type="radio"/>
Erythromycin, <i>Biaxin</i> <sup>®</sup> , <i>Zithromax</i> <sup>®</sup>		<input type="radio"/>
Codeine	Such as <i>Robitussin AC</i> <sup>®</sup> , <i>Tylenol #3</i> <sup>®</sup>	<input type="radio"/>
Non-steroidal anti-inflammatory drugs (NSAIDs)	Such as ibuprofen, <i>Advil</i> <sup>®</sup> , <i>Motrin</i> <sup>®</sup>	<input type="radio"/>
Aspirin (salicylates)		<input type="radio"/>
Sulfa drugs	Such as <i>Septra</i> <sup>®</sup> , <i>Bactrim</i> <sup>®</sup> , TMP/SMX	<input type="radio"/>
Iodine		<input type="radio"/>
If there is an allergy to a medication that is not listed above, please print the name of that medication in the space below. Example: <i>morphine</i>		

**Section 5: Medical Conditions.** Please fill in a circle **ONLY** if a doctor ever said that you have had any of the following conditions.

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

**Please return the questionnaire along with your prescriptions and your completed Medco By Mail order form in the envelope provided.**

**Did you complete both sides?**

**Thank you very much.**

