Health, Allergy & Medication Questionnaire (HMQ)

medco®

Your answers to the following questions will help us provide your prescription drug benefit services, including 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 person in the household eligible for pharmacy benefits through **the Medco Pharmacy.**
- If you need additional forms, you may call your Highmark Member Service toll-free number, or you may print a form online at **www.highmarkbcbs.com**.
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact

Group Number | Member Number (Located on your current ID card or in your benefit information) | Area Code Daytime Telephone Number

Member/Subscriber First Name | M.I. | Last Name

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

Section 2: Drug Allergy Conditions

For each covered family member, include their 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 your medication 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.

	Member	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Add last name if different than member					
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
Penicillin/cephalosporin antibiotics (e.g., ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g., Tylenol #3®)	○	○	○	○	○
Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen)	○	○	○	○	○
Aspirin (e.g., salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided (e.g., morphine)					

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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 that condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol (hypercholesterolemia)	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema (COPD)	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever (allergic rhinitis)	○	○	○	○	○
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 (peripheral vascular disease)	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine Headaches	○	○	○	○	○
Print other medical conditions not listed above in the space provided (e.g., cancer)					

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

Did you complete both sides? **Thank you very much.**