

Welcome to ExpressMed. Your Cooperation in completing this questionnaire is important. Your responses will enable ExpressMed to discuss drug interactions, side-effects, adverse reactions, or any medication problems with your doctor.

MEMBER INFORMATION

First Name	MI	Last Name
Home Phone	Work Phone (Include area code)	
Email Address (Optional)		

INSURANCE INFORMATION

Member ID	Group ID (On your Member ID Card [If Applicable])
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ADDRESS

Address 1 (Street Address)		
Address 2 (Apartment #, Suite #, Etc)		
City	State	Zip
Home Phone	Work Phone (Include area code)	
Email Address (Optional)		

Member / Dependant

	Member/Self	Spouse	Dependant	Dependant	Dependant	Dependant
Last Name						
First Name						
Doctor Name						
Doctor Phone						

Allergic Conditions

Aspirin						
Codeine						
Iodine						
"Mycin" Drugs (i.e. Erythromycin)						
Non-steroidal anti-inflammatory drugs (NSAID)						
Penicillins						
Cephalosporins						
Antibiotics (i.e. Ampicillin, Keflex)						
Sulfa Drugs						
Tetracycline						
Other						

Medical Conditions

	Member/Self	Spouse	Dependant	Dependant	Dependant	Dependant
Allergies: hay fever, etc						
Arthritis						
Asthma						
Chronic Bronchitis/ COPD						
Depressions						
Diabetes						
Enlarged Prostrate/ BPH						
Gastric reflux/ GERD						
Glaucoma						
Heart Attack or Angina						
Heart Failure/ Weak Heart						
High Blood Pressure						
Inflammatory Bowel Disease						
Migraine Headaches						
Osteoporosis						
Seizures						
Stroke						
Thyroid Disease						
Trouble with Blood						
Ulcers (Peptic, stomach, etc.)						
Vascular Disease						
Other						

Additional Comments

Please sign and date below to complete the questionnaire.

I certify that the information on this form is correct.

Member's Signature _____

Date _____