

Date of Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Chart #: \_\_\_\_\_ Athena ID#: \_\_\_\_\_

Prescription Plan Name: \_\_\_\_\_ Ins. ID # \_\_\_\_\_  
(i.e. Insurance Company)

**PATIENT QUESTIONNAIRE**

The following information below will help in obtaining medication authorization in the event your insurance company requires it. If authorization is required, there may be a delay in obtaining your medication.  
Thank You!

**Have you ever taken ANY of the medications listed below? (Check all that apply)**

- |  |                                    |                                      |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Ibuprofen (Motrin/Advil/Nuprin) | <input type="checkbox"/> Naprosyn  | <input type="checkbox"/> Daypro      |
| <input type="checkbox"/> Naproxen (Aleve)                | <input type="checkbox"/> Voltaren  | <input type="checkbox"/> Lodine      |
| <input type="checkbox"/> Relafen                         | <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Oruvail     |
| <input type="checkbox"/> Cataflam                        | <input type="checkbox"/> Orudis KT | <input type="checkbox"/> Other _____ |

**Please check ANY side effects you experienced while taking these medications: (Check all that apply)**

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Ulcer    | <input type="checkbox"/> Other _____   |

**Have you every taken ANY of the medications listed below? (Check all that apply)**

- |  |                                   |                                   |
|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pepcid  | <input type="checkbox"/> Tagament | <input type="checkbox"/> Axid     |
| <input type="checkbox"/> Zantac  | <input type="checkbox"/> Prilosec | <input type="checkbox"/> Prevacid |
| <input type="checkbox"/> Maalox  | <input type="checkbox"/> Mylanta  |                                   |
| <input type="checkbox"/> ANY medication for an Ulcer or Gastric Reflux, please list: _____ |                                   |                                   |

**Have you ever been diagnosed as having ANY of the ailments listed below? (Check all that apply)**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> History of gastrointestinal bleed?    | If yes, date _____                   |
| <input type="checkbox"/> Heartburn                             | <input type="checkbox"/> Ulcer(s)    |
| <input type="checkbox"/> Reflux                                | <input type="checkbox"/> Esophagitis |
| <input type="checkbox"/> Other Gastrointestinal Disorder _____ |                                      |

**History**

- |   |     |    |
|---|-----|----|
| Have you demonstrated an allergic reaction to Sulfa (Bactrim/Septra).....   | Yes | No |
| Do you currently take an anticoagulant medication? (Coumadin/warfarin)..... | Yes | No |
| Do you currently take a low-dose aspirin (325 mg or less) per day? .....    | Yes | No |
| Do you currently take any oral corticosteroids? (i.e. Prednisone).....      | Yes | No |
| Do you have a history of osteoarthritis? .....                              | Yes | No |
| Do you have a history of rheumatoid arthritis? Duration _____ .....         | Yes | No |

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PLEASE RETURN THIS QUESTIONNAIRE AT TIME OF REGISTRATION. THANK-YOU**