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PERSONAL HEALTH QUESTIONNAIRE

(To be filled in only for the 1st order and in case of changes)

This information is very important for your Health. It enables us to determine a possible allergy for you to some products. **Your answers are optional** and will be kept strictly confidential. See our **Privacy Policy**.

Any known allergy ?

penicillin codeine aspirin

other allergies (specify) : _____

Are you suffering from illnesses, such as:

thyroid diabetes

asthma high eye pressure

rheumatism heart ailments

hypertension (high blood pressure)

stomach ache and/or intestinal

others (specify) _____

Are you pregnant ? Are you Breast feeding ?

yes no yes no

Are you currently taking any other drug beside the ones on your medical prescripition?

I'm NOT currently taking any other drug.

Height: _____ cm

Weight: _____ Kg

Date of birth: _____

IMPORTANT : Kindly please confirm that you are informed and aware that you must immediately contact your healthcare provider in case of any problem related to the drugs sent to you.

Date : _____

Signature : _____