Northwest Pharmacy

Cold Sore Questionnaire and Evaluation

First Name M.I. Last Name ☐ Male or ☐ Female Date of Birth (DOB)

Full Street Address (PO Box acceptable if given with physical address) Phone

Allergies: ☐ No Known Allergies ☐ Penicillin ☐ Sulfa ☐ Latex ☐ NSAIDS (ibuprofen, naproxen, etc.) ☐ Other: _____

Medical Conditions: ☐ No Known Medical Conditions ☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Asthma ☐ Arthritis ☐ Depression ☐ Anxiety ☐ Immunocompromised ☐ Migraines ☐ Chronic Pain ☐ Acid Reflux ☐Other:_____

PLEASE COMPLETE THE FOLLOWING SCREENING QUESTIONNAIRE TO THE BEST OF YOUR KNOWLEDGE. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE PHARMACIST.

		(Circle Your Answer)	
1	Are you UNDER **6** years of Age?	Yes	No
2	Is this your first cold sore/fever blister?	Yes	No
3	In the last 48 hours, please check any symptoms you may be experiencing: ☐ Itching, tingling, burning, or pain around the mouth or lesion ☐ Appearance of small, fluid filled blisters around or near the lips ☐ Fever ☐ Body aches, swollen glands, or general body discomfort		
4	Have you had these symptoms for longer than 48 hours?	Yes	No
5	Is there a chance you could be pregnant?	Yes	No
6	Are you immunocompromised by a medication or condition?	Yes	No
7	Have you gotten cold sores more than 6 times in the last 12 months?	Yes	No

Signature Date

---------- *Pharmacy Use Below This Point* ----------

1. Does the patient present with VISIBLE signs of a cold sore? **Yes** **No**

2. Are all *INCLUSION* Criteria met?
   - Prodromal symptoms **and** **Yes** **No**
   - A lesion that has lasted **<48h** **Yes** **No**

3. Does the patient meet any *EXCLUSION* Criteria?
   - Circled "YES" on Items **1, 2, 4, 6, or 7.** **Yes** **No**
   - The lesion seems excessively red, swollen, or contains pus **Yes** **No**
   - The lesion is on an area other than around the mouth or lips **Yes** **No**
   - Lesions have not healed from a prior episode **Yes** **No**
   - Has symptoms of systemic illness **Yes** **No**

If the patient has ANY reason for exclusion, they should be referred to a primary care provider for further evaluation. Treating a patient that does not meet the stated criteria is not within the pharmacist's legal authority.

Patient Name_____ **DOB** _____

The following is the final recommendation and prescription of the pharmacist based on their clinical experience, knowledge, and evaluation of the patient.

☐ **Self-Care**

-Lip balm with zinc oxide
-Moisturizing cream for dry lips
-Cold compress to reduce redness
-Warm compress to ease pain

☐ Acetaminophen (Tylenol) Dose:_____
☐ Ibuprofen (Motrin, Advil) Dose:_____

☐ **Abreva (docosanol)**

#1 tube
Sig: Apply a small amount to the affected area 5x/day until healed. Max of 5 days

☐ **Valacyclovir 1g tablets**

#4 tablets
Sig: 2 tablets po BID x 2 doses

☐ Acyclovir 400 mg Tablets (Not First Line)

#25 tablets
Sig: 1 tablet po 5x/d x 5 days ICD10: B00.1

_____ _____
Pharmacist Signature Date