Northwest Pharmacy

Yeast Infection 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 **18** years of Age?	Yes	No
2	Is this your first yeast infection?	Yes	No
3	In the last 72 hours, please check any symptoms you may have experienced: ☐ Itching of the external genital area ☐ Redness of external vaginal area ☐ White or yellow discharge		
4	Have you noticed any open sores or wounds on the genitals?	Yes	No
5	Have you experienced a FEVER or BODY ACHES/CHILLS?	Yes	No
6	Is there a chance you could be pregnant?	Yes	No
7	Are you immunocompromised by a medication or condition?	Yes	No
8.	Have you gotten yeast infections more than 6 times in the last 12 months?	Yes	No

Signature ______ Date

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

1. Are all *INCLUSION* Criteria met?
   - Symptoms consistent with an *uncomplicated* yeast infection **and** **Yes** **No**
   - Pt. has had a yeast infection previously **Yes** **No**

2. Does the patient meet any *EXCLUSION* Criteria?
   - Circled "YES" on Items **1, 2, 4, 5, 6, 7, or 8.** **Yes** **No**
   - The infection is excessively red, swollen, or contains pus **Yes** **No**
   - The infection has symptoms consistent with a Sexually Transmitted Infection (STI) **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.

☐ **Tioconazole 6.5% vaginal cream (Monistat 1)**
#1 applicator
Sig: Insert 1 applicatorful qhs once

☐ **Miconazole Vaginal Cream Combination Pack (Monistat 3)**
3 applicators and 1 tube (1 box)
Sig: Insert 1 applicatorful vaginally qhs for 3 days and apply topical cream externally bid prn for 7 days

☐ Terconazole 80 mg vaginal (Terazol 3)
#3 suppositories
Sig: Insert 1 suppositories vaginally qhs for 3 days

☐ **Fluconazole 150 mg Tablet**
#1 Tablet
Sig: 1 tablet po as single dose ICD10: B37.3

____ ________________

Pharmacist Signature Date