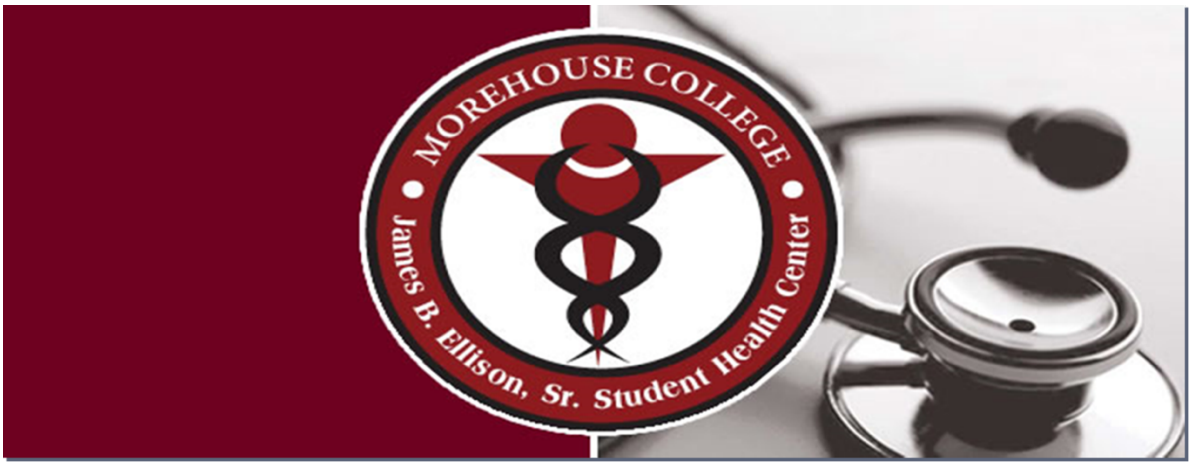

Medical Questionnaire for Malarone

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

1. Are you allergic to Atovaquone, Proguanil, Malarone? Yes No
2. Do you have kidney disease? Yes No
3. Are you taking Tetracycline, Doxycycline, Metoclopramide (Reglan), Rifampin, Rifabutin, or any product containing Proguanil (Paludrine) or Atavaquone (Mepron) other than Malarone? Yes No

Patient Informed Consent:

I have completed this form to the best of my ability and certify that I am the recipient of the Malarone requested. I have had the opportunity to discuss the risks and benefits of Malarone and my questions have been answered to my satisfaction.

Patient Signature:_____ Date_____

Reviewed by:_____ Date_____