Questions to answer after my medicines review

You can print and complete this form after your medicines review to support future discussions with your healthcare professional.

Your name……

Date of birth……..

Date of completing the form……

Date of your medicines review……

Part 1: Understanding my medicines

1.1 Overall, did your medicines review help your understanding of your medicines?

Please circle the correct response Yes / No / Not applicable

1.2 Would you still like to understand better what any of your medicines are for?
Please tick one response:

- ☐ Yes - for many of my medicines
- ☐ Yes - for several of my medicines
- ☐ Yes - for just a few of my medicines
- ☐ No - I have sufficient understanding

1.3 Would you still like to understand better the problems that any of your medicines may cause? *Please tick one response:*

- ☐ Yes- for many of my medicines
- ☐ Yes – for several of my medicines
- ☐ Yes – for just a few of my medicines
- ☐ No – I have sufficient understanding

1.4 In your last medicines review were your views and concerns fully considered, to help you to arrive at a joint decision with your healthcare professional? *Please tick one response:*

- ☐ My views and concerns were fully considered
- ☐ Most of my views and concerns were considered
- ☐ Some of my views and concerns were considered
- ☐ None of my views and concerns were considered
- ☐ I haven't had a medicines review before

Please note any questions you still have about what your medicines are for. You can also provide details of issues you would like to be more fully considered.

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Part 2: Medicines and my daily life

2.1 Overall, did your medicines review help with side effects you are experiencing from your medicines?

Please circle the correct response Yes / No / Not applicable

2.2 Do you think you may still be experiencing side effects from your medicines?

Please circle the correct response Yes / No

2.3 If you think you are still experiencing side effects, please tick all that apply from the list below:

- ☐ Constipation
- ☐ Diarrhoea
- ☐ Dizziness

- ☐ Drowsiness
- ☐ Dry mouth
- ☐ Headache
- ☐ Insomnia (unable to sleep)
- ☐ Skin rash
- ☐ Loss of appetite
- ☐ Sleepiness during the day
- ☐ Other - *please provide details*

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2.4 Under each heading below, please tick the ONE box below that best described your health TODAY

Mobility

- ☐ I have no problems walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

Self-care (If you need further help with self-care, please contact your health service)

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual activities

- ☐ I have no problem performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

Pain/discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety/depression (Note - if you are extremely anxious or depressed you should contact your health service immediately for help and support

- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

2.5 Are the effects of your medicines still impacting on your daily activities? If so, please select below the areas affected that matter most to you (up to 3)

- ☐ Work
- ☐ Social life
- ☐ Relationships – e.g. family, friends, partners
- ☐ Daily routines – e.g. cooking, dressing, driving, housework, shopping
- ☐ Taking exercise
- ☐ Interests and hobbies
- ☐ Other – please provide details.
- ☐ Not applicable

2.6 Overall, did your medicines review help with the impact of medicines on your daily activities?

Please circle the correct response Yes / No / Not applicable

Please enter any questions or comments about your health or daily activities that you would still like to discuss with your healthcare professional. Include any side effects that were not listed. Also include any activities affected by your medicines that matter most to you that were not listed.

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Part 3: Taking my medicines correctly

3.1 Overall, did your medicines review help you to take your medicines correctly?

Please circle the correct response Yes / No / Not applicable

Thinking about taking your medicines over the past week, please circle the correct response to each question:

3.2 Did you ever forget to take your medicines? Yes / No

3.3 Did you ever have problems remembering to take your medicines? Yes / No

3.4 At times when you felt better, did you stop taking one or more of your medicines? Yes / No

3.5 If you felt worse when you took a medicine, did you stop taking it? Yes / No

3.6 Did you ever take more medicines than prescribed, or take medicines for a different purpose than prescribed? Yes / No

Please provide more information about any problems you still experience in taking your medicines correctly.

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