Best Possible Medication History: Interview Guide

Hello Mr./Mrs./Ms./Miss._____***(client/patient/ resident)***

My name is_____, ***(introduce self/profession)***

I would like to take some time to review the medications you take at home.

I have a list of medications from your chart/file, and want to make sure they are accurate and up to date. Would it be possible to discuss your medications with you (or a family member) at this time?

You may also wish to ask:

Is this a convenient time for you? Do you have a family member who knows your medications that you think should join us? How can we contact them?

MEDICATION ALLERGIES

Do you have any medication allergies? ***YES*** ☐ ***NO*** ☐

If yes: What happens when you take_____***(medication name)***?

INFORMATION GATHERING

Do you have your medication list or pill bottles (vials) with you?

Show and tell technique when they have brought the medication vials with them

How do you take_____***(medication name)***?

How often or ***When*** do you take_____***(medication name)***?

Collect information **about dose, route and frequency** for each drug. If the patient is taking a medication differently than prescribed, record what the patient is actually taking and **note the discrepancy**.

Are there any **prescription medications** you (or your physician) have recently stopped or changed?

What was the reason for this change?

COMMUNITY PHARMACY

What is the ***name of the pharmacy*** that you normally go to? ***(name/location: anticipate more than one)***

May we call your pharmacy to clarify your medications if needed?

OVER THE COUNTER (OTCs) MEDICATIONS

Are there any medications that you are taking that you do not need a prescription for? (Do you take anything that you would buy without a doctor's prescription?)

Give example, e.g. Aspirin. If yes: How do you take_____***(medication name)***?

VITAMINS/MINERALS/SUPPLEMENTS

Do you take any **vitamins** (e.g. multivitamin)? ***If yes,*** how do you take _____?

Do you take any **minerals** (e.g. calcium, iron)? ***If yes,*** how do you take _____?

Do you use any **supplements** (e.g. potassium, glucosamine, St. John's Wort)? ***If yes,*** how do you take_____?

EYE/EAR/NOSE DROPS

Do you use any **eye drops**? ***If yes,*** what are the names and how many drops do you use and how often? In which eye?

Do you use any **ear or nose drops/nose sprays**? ***If yes,*** how do you use them_____?

INHALERS/PATCHES/CREAMS/OINTMENTS/INJECTABLES/SAMPLES

Do you use any **inhalers**? any **medicated patches**? medicated **creams or ointments**? any **injectable medications** (e.g. insulin)? ***For each if yes,*** how do you take_____? ***(name, strength, how often)***

Did your doctor give you any **medication samples** to try in the last few months?

ANTIBIOTICS

Have you used any **antibiotics** in the past three months? ***If so,*** what are they?

CLOSING

This concludes our interview. **Thank you for your time. Do you have any questions?**

If you remember anything after our discussion **please contact me to update the information.**

EXIT ROOM AND WASH HANDS. PROCEED TO DOCUMENT INTERACTION IN CHART/FILE.

Note: Medical and social history, if not specifically described in the chart/file, may need to be clarified with patient

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