Managing multiple medicines

https://managemymeds.scot.nhs.uk

Questions to answer before my medicines review

You can print and complete this form before your medicines review and take a copy with you to support your discussion 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 Would you like to better understand what some 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

1.2 Would you like to better understand possible 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

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

Please circle the correct response Yes / No

2.2 If you think you are 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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2.3 Under each heading below, please tick just the ONE box 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

(Note - 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

2.4 Please select the activities affected by your medicines 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

Please enter any questions or comments about your health or daily activities that you would 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

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

3.1 Did you ever forget to take any of your medicines? Yes / No

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

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

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

3.5 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 experience in taking your medicines correctly.

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