

**DRAKE UNIVERSITY  
COLLEGE OF PHARMACY & HEALTH SCIENCES  
INTERVIEW TOOL ASSESSMENT STUDY**

DATE \_\_\_\_\_ PATIENT NUMBER \_\_\_\_\_

COMPLETED BY \_\_\_\_\_

**PATIENT CONSULTATION HISTORY FORM**

**MEDICATION LIST (IF > 8, CHOOSE 8 HIGHEST PRIORITY)**

1.	5.
2.	6.
3.	7.
4.	8.

GENERAL SAFETY				
Do you have any allergies to medications?	Describe:	Yes	No	Unsure
Do you have any food or environmental allergies?	List:	Yes	No	Unsure
Do you have any drug sensitivities?	Describe:	Yes	No	Unsure
Have you ever been told you have kidney or liver problems?	Approximate Date:	Yes	No	Unsure
NEEDS ADDITIONAL THERAPY				
Do you ever self-medicate for any conditions rather than visit your doctor?	List:	Yes	No	Unsure
Do you have any symptoms for which you are considering seeking treatment?	Describe:	Yes	No	Unsure
Are there any conditions you/your doctor are treating without medication?	List:	Yes	No	Unsure
<p>___ No problems noted based on information provided.</p> <p>___ Report all your symptoms/problems to your doctor including:</p> <p>___ Ask you doctor about prevention therapy with or for:</p>				

COMPLETED BY \_\_\_\_\_ FORM # \_\_\_\_\_ OF \_\_\_\_\_

**MEDICATION ASSESSMENT SHEET (USE FOR ≤ 4 MEDICATIONS. IF > 4, CHOOSE 4 HIGHEST PRIORITY)**

Medication Name, Strength, Labeled Directions:		Patient Study Number:		
		Prescriber:		
<b>INDICATION</b>				
What condition or symptoms are you treating with this medication?	Describe:			Unsure
Are you taking another medication for the same problem?	List:	Yes	No	Unsure
Does this medication help control a problem caused by another medication?	Describe:	Yes	No	Unsure
Do you use any non-drug therapy for this same problem?	Describe:	Yes	No	Unsure
<p>___ No problems noted based on information provided.</p> <p>___ The reason you are taking this medication may no longer exist.</p> <p>___ You are also taking _____ for the same purpose.</p> <p>___ You may be taking to treat a side effect caused by _____.</p> <p>___ You may be able to use non-drug therapy such as _____.</p>				
<b>SAFETY</b>				
Do you currently experience any undesirable effects or symptoms from this medication?	Describe:	Yes	No	Unsure
Do you use any non-prescription medication to help treat this problem/condition?	List:	Yes	No	Unsure
<b>RPh</b> – Does the patient have any allergy or hypersensitivity to this drug?	Describe:	Yes	No	Unsure
<b>RPh</b> – Is there a drug interaction that has the potential to be unsafe for this patient?	Describe:	Yes	No	Unsure
<b>RPh</b> – Should the dose be reduced due to possible renal/hepatic dysfunction?	Recommendation:	Yes	No	Unsure
<p>___ No problems noted based on information provided.</p> <p>___ The dose may be too high for your condition.</p> <p>___ A drug interaction with _____ may exist.</p> <p>___ This medication may be causing a potential adverse reaction or allergic reaction.</p>				
<b>COMPLIANCE</b>				
How many times a week do you miss a dose of this medication?	Number and reason:	Miss		Don't Miss
Do you find it difficult to pay for this medication?		Yes	No	Unsure
Do you sometimes refill this medication late?		Yes	No	Unsure
Do you ever seriously consider stopping taking this medication?		Yes	No	Unsure
Do you have any difficulty swallowing or administering this medication?		Yes	No	Unsure
Tell me how many and the times each day you take this medication.	Describe:	Incorrect		Correct
<p>___ No problems noted based on information provided.</p> <p>___ Tell your doctor why you prefer not to take this medication.</p> <p>___ Use a device to help you remember to take your medication.</p> <p>___ Ask your doctor for a medication that may be easier to swallow or administer.</p> <p>___ Remember to take according to these directions:</p>				

<b>EFFICACY</b>				
Does your doctor think this medication is working?		Yes	No	Unsure
Do you think this medication is working?		Yes	No	Unsure
Do you think your symptoms/condition are getting better or worse?		Better	Worse	Unsure
Does your doctor often adjust your dose to help treat this problem/condition?		Yes	No	Unsure
Tell me where you store this medication.	Describe:	Correct		Incorrect
<b>RPh</b> – Does the patient use an OTC for this condition to improve symptoms?		Yes	No	Unsure
<b>RPh</b> – Would an exercise program improve this drug's effectiveness for this patient?		Yes	No	Unsure
<b>RPh</b> – Would a healthier diet improve this drug's effectiveness for this patient?		Yes	No	Unsure
<b>RPh</b> – Is there a drug interaction that may be decreasing effectiveness of this drug?	Describe:	Yes	No	Unsure
<p><input type="checkbox"/> No problems noted based on information provided.</p> <p><input type="checkbox"/> Dose may be too low to get good response.</p> <p><input type="checkbox"/> A drug interaction with _____ may be lowering response.</p> <p><input type="checkbox"/> Another drug such as _____ may work better because:</p> <p><input type="checkbox"/> An additional drug may be needed because:</p> <p><input type="checkbox"/> Remember to store your medication this way:</p> <p><input type="checkbox"/> Ask your doctor if it is safe to modify your diet or exercise habits.</p>				
<b>COST</b>				
Do you sometimes find it difficult to pay for this medication?		Yes	No	Unsure
Would you be interested in a generic version if one is available?		Yes	No	Unsure
Would you be willing to try an older medication that may work as well to save money?		Yes	No	Unsure
Do you have a different co-pay for generics and/or different days supply allowed?	Describe:	Yes	No	Unsure
<b>RPh</b> – Is there a less expensive medication available for this patient that may work effectively?	Recommendation:	Yes	No	Unsure
<p><input type="checkbox"/> No problems noted based on information provided.</p> <p><input type="checkbox"/> Consider a generic version.</p> <p><input type="checkbox"/> Consider an alternative medication such as:</p> <p><input type="checkbox"/> Enroll in Senior Discount/Medicare Part D program.</p> <p><input type="checkbox"/> Consider splitting a higher strength tablet.</p> <p><input type="checkbox"/> Seek payment assistance from:</p> <p><input type="checkbox"/> Have your prescription written for a _____ day's supply.</p>				
<b>ADDITIONAL INFORMATION REQUIRED FOR RESPONSES ABOVE MARKED "UNSURE"</b>				