

Medication Review

Patient	
Name: _____	NHS Number: _____
Address: _____	Date of Birth: _____

Telephone: _____	Mobile Phone: _____
Done By	
Name: _____	Date: _____

Medication Review

We review any regular medication on a repeat prescription annually and wherever possible the doctor will do this without you having to attend the surgery.

If you have been advised by the surgery that your medication review is due, please complete the questions below. We will contact you if we need to ask further questions.

1. Please confirm your telephone number – the number, which is best to contact you on, should we need to speak to you:

2. Do you have any concerns or side effects from your medication?

Yes

No

3. If yes, why?

4. Do you know when and how to take your medication?

Yes

No

5. Do you know why you are taking your medication?

Yes

No

6. Have you nominated a pharmacy to dispense your medication?

Yes

No

7. If no, which chemist would you like us to send your prescriptions to?.....

8. We can arrange for 6 or 12 months of prescriptions to be sent to your pharmacy to save you having to order your medication each month. Would you like us to do this for you?

Yes

No

9. Do you take any medication that you have bought from the chemist? If yes, what?

10. What is your smoking status?

Smoker

Ex-smoker

Never smoked

11. Do you have any medication on your repeat list (or from your letter) that you do not take anymore?

Yes

No

12. If yes, which medication?

13*. Do you have any drug sensitivities or allergies?

Yes

No

Not known

14. If yes, please list below

15. If you are more than 45 years old, please measure your blood pressure reading with a home blood pressure monitor or the blood pressure monitor in the surgery and record below:

Systolic BP Diastolic BP Pulse rate

Thank you.

Please note: You may still need to attend for your annual reviews if you have a chronic disease.

For any question or query regards your medication, you can contact the Clinical Pharmacist at the surgery.