Date _____/_____/_____

# Medication Questionnaire

| | | | |
|---|---|---|---|
| Name | | | |
| Date of Birth | / / | Age | |
| Sex | ☐ Male ☐ Female ☐ Other ☐ Prefer not to say | | |

Who completed this questionnaire?

☐ Self (patient) ☐ Family member ☐ Caregiver / Healthcare staff ☐ Other ( )

Please answer the following questions.

**1** Have you ever had side effects from medications?

☐ No ☐ Yes (Please describe: )

**2** Do you have any allergies?

☐ No ☐ Yes (Please describe: )

**3** Do you take any over-the-counter (OTC) medicines, supplements, or herbal products?

☐ No ☐ Yes (List names: )

**4** Who manages your medications?

☐ I manage them myself ☐ I manage them with family help

☐ A family member manages them ☐ Care facility staff manage them

☐ Other( )

**5** Do you need help taking your medications?

☐ No ☐ Yes **If Yes** Type of help needed ☐ Some assistance ☐ Full assistance

Which medications require help? (Select all that apply)

☐ Oral medications ☐ Topical medications ☐ Injections

**6** Do you use any tools to manage your medications? (Select all that apply)

☐ Unit-dose packaging (blister packs) ☐ Pill organizer / medication box ☐ Medication calendar

☐ Other( ) ☐ None

**7** Do you have problems taking your medications? (Select all that apply)

☐ Forgetting doses ☐ Difficulty seeing tablets or labels

☐ Difficulty hearing instruction ☐ Difficulty removing tablets from packaging

☐ Difficulty swallowing tablets or capsules ☐ Other( ) ☐ None

**8** Do you use any methods to make medications easier to take?

☐ No ☐ Yes **If Yes**

☐ Crushing tablets

☐ Taking with medication jelly or thickened liquids

☐ Using a medication wafer (oblate)

☐ Administration via feeding tube

**9** Would you like to review or change your medications? (Select all that apply)

☐ No ☐ Yes **If Yes**

☐ I take many medications and would like fewer

☐ I would like to take medications fewer times per day

☐ Some medications are difficult to take

☐ I need advice on medication management

☐ I want more information about my medications

☐ I want to discuss possible side effects

# Possible Medication-Related Symptoms

Have you experienced the following in the past month?

If the patient cannot be asked directly, check below.

☐ Unable to confirm symptoms with the patient

## 1 Do you have daytime sleepiness?

☐ No ☐ Yes

Average sleep per day

_____ hours

## 2 In the past two weeks, have you felt unusually tired?

☐ No ☐ Yes

## 3 Have people said you repeat questions or seem forgetful?

☐ No ☐ Yes

## 4 Has your appetite decreased?

☐ No ☐ Yes

## 5 Do you feel dizzy or lightheaded?

☐ No ☐ Yes

☐ Spinning sensation (vertigo)

☐ Feeling unsteady

## 6 Have you fallen in the past 6 months?

☐ No ☐ Yes

## 7 Do you have difficulty urinating?


☐ No ☐ Yes

Times per day

Daytime Nighttime _____

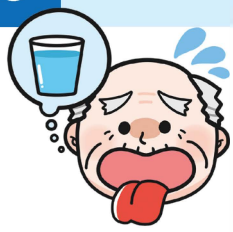
## 8 Do you have difficulty with bowel movements?

☐ No ☐ Yes

Average frequency

Once every days

## 9 Are you bothered by dry mouth?



☐ No ☐ Yes

## 10 Do you cough or choke when drinking liquids?

☐ No ☐ Yes

Thank you for completing this questionnaire.

National Center for Geriatrics and Gerontology