M:CR Pharmaceutical Care Plan

Pharmacy and Medicines

Please answer the questions below to enable us to assess your suitability for a long term prescription. If you have any questions, please ask us for more information.

NAME:		DOB:	
CONTACT NUMBER:			

Please answer YES/ NO to the following questions: *(delete as appropriate)*

Do you know the names of your medicine and why you take them? YES / NO
Do you ever forget to take your medicine or choose not to? YES / NO
Do you know what to do if you miss a dose of your medication? YES / NO
Do you ever experience any side effects from your medication? YES / NO
If yes please list below:

Do you understand why it is important to take your medication as prescribed? YES / NO
Do you have regular blood tests, check-ups and medication reviews with your GP? YES / NO

Females only
Are you pregnant? YES / NO Are you breastfeeding? YES / NO

Current Smoker? YES / NO Previous smoker? YES / NO Considering Quitting? YES / NO

Any Allergies / Sensitivities: YES / NO *If yes, please list below:*

Any known impairments eg. Swallowing, physical, dexterity, visual, hearing impairments? YES / NO
If yes, please list below:

Any Kidney, liver, lung or immune system problems? YES/NO
If yes, please list below:

Please list your medical conditions:

If you have any issues or concerns around taking your medication or if you are experiencing any side effects from your medicines, please speak to the pharmacist today.

Pharmacy and Medicines

NHS Fife