Qualis Health Presentation Handout
Tips for Obtaining Best Possible Medication History
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Start with easily accessible sources
• Outpatient medication list
• Recent hospital discharge orders
• Patient’s own personal medication list
• Assume all medication lists are inaccurate

Start by having patient tell you what they are taking in their own words (i.e., don’t lead the patient with yes/no questions based on the list)
• More likely to learn about discrepancies
• Helps to assess their medication understanding and adherence
• Double-check patient report with family or caregiver if possible

If no medication list is available, consider the following prompts
• What medications do you take at home every day?
• Which medications do you take only sometimes?
• What symptoms prompt you to take them?
• How many doses per week do you take?
• What’s the most often you are allowed to take it?
• Do you often take something for headaches, allergies, to fall asleep, when you get a cold, for heartburn?
• For all medications, ask about the dose, time(s), formulation, and route of administration

Fill in gaps with follow-up questions
• What is that medicine for? Do you take anything else for that?
• What medications do you take for XXX condition?
• Do your other doctors (specialists, naturopaths, nurse practitioners) prescribe any other medications for you?
• Do you use inhalers, nasal sprays, skin creams, eye drops, ear drops, skin patches, injections, or suppositories?
• Do you take any medications in the evening or at night?
• Do you take any medications once a week or once a month?
• What medications or supplements do you take that don’t require a prescription?

Ask about adherence
• When did you take the last dose of that medication?
• Tell me about any problems that you’ve had taking these medications as prescribed?
• Many patients have difficulty taking their medications exactly as they should every day. In the last week, how many days have your missed a dose of your xxx?

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