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 assesses 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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