Appendix A – Baseline Medication questionnaire

Patient Name:-_____ Date:_____

Project Site:_____

Interviewer ID _____

Medication Questionnaire

1. How many medications do you take on a daily basis?_____

Please list your medications if you know them:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

2. Do you know why you take each medication? **Circle, Yes or No**

3. Do you feel like you could benefit from more counseling on your medications? **Circle, Yes or No**

4. Have you ever stopped taking a prescribed medication in the past without your doctor's knowledge? **If so, why did you stop it?**

5. Are up having difficulty taking your medications: circle **yes, no, or sometimes**

6. Do you having difficulty reading your pill bottles**? Yes or no**

7. It is difficult to pay for your medications? **Circle Yes or no**

8. Do you have unwanted side effects from your medications? **Circle yes, no, or sometimes**. If **yes,** what side effects are you experiencing?

9. Would you mind if you were called in two weeks to check on you?

Please list your preferred phone number and what time of the day is best to call you: _____Time of day_____

Thank you so much for participating!

Appendix B – Medication card

Medication Card

Medication Name/dose	Generic name of medication	Reason for taking	AM	Lunch	PM
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					