Intro:

Shake hands, introduce everyone in the room

What is your understanding of the reason for our visit today? Clarify as needed (pharmacists)

What are their concerns regarding medications? Any of the following? Others?

* Medication Costs
* Too many medications
* Help understanding your medications
* Weight gain
* Medications aren’t working
* Insomnia

Prescription Medications: Review med list in EMR and update

Other Medications

* Multivitamins, other vitamins
* Calcium/vitamin D
* Herbal medicine or nutritional supplements
* Hormones/Birth Control
* Headaches/ aches and pains
* Cough or cold
* Allergy/hay fever
* Inhalers, eye drops, nasal sprays
* Upset stomach, heartburn, diarrhea, constipation
* OTCs for sleep or anxiety
* Medicated creams, lotions, or patches
* Samples, internet, friends, family
* Anything stopped in recent past

Allergies/ADRs (review in EMR first):

* Allergies
* ADRs

Devices:

* CPAP machine? Are you using it?
* Oxygen
* Wheelchair, walker

Social History

* Tobacco – smoke, chew, electronic. Are you ready to quit?
* Caffeine – coffee, tea, soda, energy drinks
* Alcohol – none, rare, how often, how much? When is the last time you had a drink?
* Exercise/activity
* Dairy products for calcium intake – milk, yogurt, cheese
* Marijuana, other drugs

Review of Systems (***if needed*** to assess for ADRs)

* Skin rash
* Aches, pains, headaches
* Dry eyes, blurred vision
* Dry mouth
* Heart – lightheadedness, fainting, palpitations
* Trouble breathing
* GI - Nausea, vomiting, heartburn
* Bowel, bladder problems – constipation, sexual dysfunction
* Appetite
* Easy bruising, bleeding
* Tremor, other unusual movements
* Memory

Family History (***if applicable***)

* Has anyone in your family (parents, brother/sister) died of a heart attack at an early age? (Males < 55, females < 65)

Adherence

* Do you use some type of reminder system such as a pill box?
* Are you out of any of your medications right now?
* ***How often do you miss taking your medications?***

Immunizations (review documentation in chart first)

* Flu shot (***during flu season***)
* Tdap every 10 years?
* Pneumonia q5 yrs (PCV13, Prevnar at 65, PPSV23, Pneumovax23 in 6-12 mos).
* Shingles once over 55/60 or as appropriate

Do you have other providers?

* Other doctors (Psychiatrist?) Other specialists?
* Case manager
* Therapist

Additional Information

* Are your medications working as well as you would like? Causing side effects?
* Assess health literacy as needed (How happy are you with your ability to read?)
* Additional rating scales as needed (GAD-7, MDQ, sleep assessment etc)
* Sign records releases

Wrap Up

* Do you have any additional information or questions?
* Review objective goals of therapy with patient (BP, HbA1c, etc)
* Discuss any immediate recommendations
* Teach back (“I would like to make sure I explained myself clearly”)
* Schedule follow-up with PCP and/or pharmacy