Medication Review Worksheet

A discussion guide for health care professional-patient conversations about medication

Patient’s Name: ____________________________________________________________

Name of Medication: _____________________________________________________

This Medication is being taken for (list condition): __________________________

Required Dosage (i.e., how much medicine you should take): ________________

Circle day or days when you’ll take this medication

Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Indicate which part of the day you must take this medication

☐ Morning  ☐ Afternoon  ☐ Early Evening  ☐ Before Bed

Show the time(s) when you must take this medication

☐ Morning  ☐ Afternoon  ☐ Early Evening  ☐ Before Bed

Check off what you must know about this medication

☐ Keep in refrigerator.  ☐ Should be taken with food.

☐ Do not drive or operate machinery while taking this medicine.

☐ No alcoholic beverages while taking this medicine.

☐ Other instructions: ____________________________________________________

Circle the following side effects you’ve been instructed to watch for (The health care professional should describe each of the potential side effects in easily understood layman’s terms.)

Drowsiness  Nausea  Shortness of Breath  Palpitations  Dizziness  Diarrhea
Abdominal Pain  Blurred Vision  Headache  Loss of Appetite  Memory Loss