[Comprehensive Medication Review]

Patient ID Number	Male/Femal	Date of Birth
Patient Last Name		
Patient First Name	**Date of Review**	

Please rank the following 1 through 6

1= most important
6 = least important

_____ **Avoiding medicine side effects**
_____ **Organizing my medications**
_____ **Reducing my medication expenses**
_____ **Reducing/managing my symptoms**
_____ **Simplifying my daily dosing schedule**
_____ **Using generic medications**

Patient Health Care Priority

Comfort ☐

Avoiding medicine side effects is important to me.
Reducing/managing my symptoms is important to me.

Convenience ☐

Simplifying my drug therapy is important to me.
Organizing my medication is important to me.

Cost ☐

Reducing my medication expenses is important to me.
Using generic medications is important to me.

Current Diagnosed Diseases	Undiagnosed Diseases

A ☐ Asthma/COPD	D ☐ Diabetes	G ☐ Hyperlipidemia	J ☐ Migraine Headaches	M ☐ Thyroid Disorder
B ☐ Cardiovascular Disease	E ☐ GERD/PUD	H ☐ Hypertension	K ☐ OA/RA	N ☐ Other _____
C ☐ Depression	F ☐ Heart Failure	I ☐ Mental Health Condition	L ☐ Osteoporsis	O ☐ Other _____

Patient Medications

Name/Strength	How do you take	Effectiveness/Complications	Prescriber

Patient Concerns/Notes

Name/Strength	How do you take	Effectiveness/Complications	Prescriber

Patient Concerns/Notes

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