Medication Inventory Follow Up

PID: 0 **Acrostic:** 0 **Visit:**

Date Form Completed: d_form

Administration Type: admin

Reviewed by: compby

Language: language

Medication Inventory

1. **We are interested in the prescription medications you are using. We are particularly interested in medications your doctor prescribed for you and were filled by a pharmacist. These include pills, skin patches, eye drops, creams, salves, and injections. The letter you received about this appointment asked you to bring them to the clinic. Have you brought them with you? Are these all the medications that you took in the last two weeks?**

   mibringem

   1 Yes
   2 No
   3 Took no meds
   9 Refused

NOTE: This list will not be refreshed until form is saved.
Select 'Edit Medication List' to view current selection of medications.

Selected drugs/medications:

1. PULMICORT

Additional drugs previously entered:
[*none*]

Enter drugs that did not appear in the master drug list here. Please enter one medication per field.

mimed16 1.

mimed17 2.

mimed18 3.

mimed19 4.

mimed20 5.

mimed21 6.

mimed22 7.

mimed23 8.

mimed24 9.

mimed2510.

Specific Medications

2. Were any of these medications you took during the past two weeks for...

a. High blood pressure? mihighbp

1 Yes
2 No
9 Don't know

b. Angina or chest pain? michstpn

1 Yes
2 No
9 Don't know

c. Control of heart rhythm? mihrtrhy

1 Yes
2 No
9 Don't know

d. Heart failure? mihrtfail

1 Yes
2 No
9 Don't know

e. Blood thinning? mibldthn

1 Yes
2 No
9 Don't know

f. Stroke? mistroke

1 Yes
2 No
9 Don't know

g. Leg pain on walking? milegpn

1 Yes
2 No
9 Don't know

h. Depression? midep

1 Yes
2 No
9 Don't know

i. Weight loss? miwgtloss

1 Yes
2 No
9 Don't know

j. Cholesterol lowering? michlower

1 Yes
2 No
9 Don't know

3. During an average week, how often do you take one or more aspirin tablets? (Do not include Tylenol, Ibuprofen or similar drugs)

miaspirin

1 Never or less than 1 day per week
2 1 or 2 days per week
3 3-4 days per week (every other day)
4 5 or 6 days per week
5 Every day

MY HEALTH, PART A.
ANNUAL – OUT YEARS

Patient ID	[affix ID label here]	Date Form Completed	__ __ / __ __ / __ __ (Month / Day / Year)
Administration Type		Visit Code	
Reviewed by		Language	E

Medication Inventory

1. We are interested in the prescription medications you are using. We are particularly interested in medications your doctor prescribed for you and were filled by a pharmacist. These include pills, skin patches, eye drops, creams, salves, and injections. The letter you received about this appointment asked you to bring them to the clinic. Did you bring all of the medications that you took in the last two weeks?

   1 ☐ Yes ➔ May I see them?

   2 ☐ No ➔ Make arrangement to obtain

   3 ☐ Took no meds ➔ **Go to question 3, next page**

   9 ☐ Refused

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______

Specific Medications

"Now I would like to ask you about a few specific medications."

2. "Were any of these prescription medications you took during the past two weeks for: . . ."

a.	High blood pressure?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
b.	Angina or chest pain?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
c.	Control of heart rhythm?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
d.	Heart failure?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
e.	Blood thinning?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
f.	Stroke?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
g.	Leg pain on walking?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
h.	Depression?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
i.	Weight loss?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know
j.	Cholesterol lowering?	1 ☐ Yes	2 ☐ No	9 ☐ Don't know

3. During an average week, how often do you take one or more aspirin tablets? (Do not include Tylenol, ibuprofen or similar drugs)

1 ☐ Never or less than 1 day per week
2 ☐ 1 or 2 days per week
3 ☐ 3-4 days per week (every other day)
4 ☐ 5 or 6 days per week
5 ☐ Every day

Diabetes

4. In the past 12 months, have you been told that your diabetes has affected the back of your eye, that is, the retina?
(Do not include treatment for cataracts or glaucoma)

1 ☐ Yes

2 ☐ No

5. In the past 12 months, have you been told that your diabetes has affected your kidneys?

1 ☐ Yes

2 ☐ No

Neuropathy

6. **Please answer the questions below about the feeling in your legs and feet. Check yes or no based on how you usually feel.**

	Question	Yes	No
a.	Are your legs and/or feet numb?	1 ☐ Yes	2 ☐ No
b.	Do you ever have any burning pain in your legs and/or feet?	1 ☐ Yes	2 ☐ No
c.	Are your feet too sensitive to touch?	1 ☐ Yes	2 ☐ No
d.	Do you get muscle cramps in your legs and/or feet?	1 ☐ Yes	2 ☐ No
e.	Do you ever have any prickling feelings in your legs or feet?	1 ☐ Yes	2 ☐ No
f.	Does it hurt when the bed covers touch your skin?	1 ☐ Yes	2 ☐ No
g.	When you get into the tub or shower, are you able to tell the hot water from the cold water?	1 ☐ Yes	2 ☐ No
h.	Have you ever had an open sore on your foot?	1 ☐ Yes	2 ☐ No
	If yes ➔ Do you have one now? 1 ☐ Yes 2 ☐ No		
i.	Has your doctor ever told you that you have diabetic neuropathy?	1 ☐ Yes	2 ☐ No
j.	Do you feel weak all over most of the time?	1 ☐ Yes	2 ☐ No
k.	Are your symptoms worse at night?	1 ☐ Yes	2 ☐ No
l.	Do your legs hurt when you walk?	1 ☐ Yes	2 ☐ No
m.	Are you able to sense your feet when you walk?	1 ☐ Yes	2 ☐ No
n.	Is the skin on your feet so dry that it cracks open?	1 ☐ Yes	2 ☐ No

Congestive Heart Failure/Breathlessness

7. Have you ever had to sleep on 2 or more pillows to help you breathe?

   1 ☐ Yes ➔ Do you currently have to sleep on 2 or more pillows to help you breathe?
   - 1 ☐ Yes
   - 2 ☐ No

   2 ☐ No

8. Have you ever been awakened at night by trouble breathing?

   1 ☐ Yes ➔ Do you currently wake up at night due to trouble breathing?
   - 1 ☐ Yes
   - 2 ☐ No

   2 ☐ No

9. Have you ever had swelling of your feet or ankles (excluding during pregnancy or because of an injury such as a sprain)

   1 ☐ Yes ➔ Did it come on during the day and go down overnight?
   - 1 ☐ Yes
   - 2 ☐ No

   Do you currently have swelling of your feet or ankles?
   - 1 ☐ Yes ➔ Does it come on during the day and go down overnight?
     - 1 ☐ Yes
     - 2 ☐ No
   - 2 ☐ No

   2 ☐ No

10. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

    1 ☐ Yes ➔ When walking on level ground, do you have to walk slower than people your age because of breathlessness?
    - 1 ☐ Yes
    - 2 ☐ No

    Do you ever have to stop for breath when walking at your own pace on level ground?
    - 1 ☐ Yes
    - 2 ☐ No

    2 ☐ No

Leg Pain/Claudication

11. Do you get pain in either leg on walking?

- 1 ☐ Yes → Does this pain ever begin when you are standing or sitting?
  - 1 ☐ Yes → In what part of your leg do you feel it?
    - 1 ☐ In calf → Do you get it if you walk uphill or hurry?
      - 1 ☐ Yes → Do you get it if you walk at an ordinary pace on the level?
        - 1 ☐ Yes
        - 2 ☐ No

        Does the pain ever disappear while you are walking?
        - 1 ☐ Yes
        - 2 ☐ No

        What do you do if you get it when you are walking?
        - 1 ☐ Stop or slow down → What happens to it if you stand still? Is it relieved?
          - 1 ☐ Relieved → How soon?
            - 1 ☐ ≤ 10 minutes
            - 2 ☐ > 10 minutes
          - 2 ☐ Not relieved

          Were you ever hospitalized for this problem in your legs?
          - 1 ☐ Yes
          - 2 ☐ No
        - 2 ☐ Carry on
      - 2 ☐ No
    - 2 ☐ NOT in calf
  - 2 ☐ No
- 2 ☐ No

Sleep Apnea

The following questions are about snoring and breathing during sleep. Please consider both what others have told you and what you know about yourself.

12. Have you ever snored (now or at any time in the past)?
    - 1 ☐ Yes
    - 2 ☐ No ➔ Skip to question #15
    - 9 ☐ Don't know ➔ Skip to question #15

13. How often do you snore now?
    - 1 ☐ Do not snore any more ➔ Skip to question #15
    - 2 ☐ Sometimes (up to 2 nights a week)
    - 3 ☐ Frequently (3-5 nights a week)
    - 4 ☐ Always or almost always (6-7 nights a week)
    - 9 ☐ Don't know

14. How loud is your snoring?
    - 1 ☐ Only slightly louder than heavy breathing
    - 2 ☐ About as loud as talking
    - 3 ☐ Louder than talking
    - 4 ☐ Extremely loud – can be heard through a closed door
    - 9 ☐ Don't know

15. Are there times when you stop breathing during your sleep?
    - 1 ☐ Yes
    - 2 ☐ No ➔ Skip to question #17
    - 9 ☐ Don't know ➔ Skip to question #17

16. How often do you have times when you stop breathing during your sleep?
    - 1 ☐ Sometimes (up to 2 nights a week)
    - 2 ☐ Frequently (3-5 nights a week)
    - 3 ☐ Always or almost always (6-7 nights a week)
    - 9 ☐ Don't know

17. How often do you feel excessively (overly) sleepy during the day?
    - 1 ☐ Never or rarely (1 day/month or less)
    - 2 ☐ Sometimes (2-4 days/month)
    - 3 ☐ Often (5-15 days/month)
    - 4 ☐ Almost always (16-30 days/month)

Sleep Apnea

18. Have you ever been told by a doctor that you had sleep apnea (a condition in which breathing stops briefly during sleep)?

1 ☐ Yes

2 ☐ No

Health Care

19. Which <u>one</u> of the following health care facilities best describe your <u>usual source of health care</u>?

(Check one.)

1 ☐ Private doctor's office

2 ☐ Hospital clinic or outpatient department

3 ☐ Community health center

4 ☐ Other kind of health care facility

5 ☐ No usual source of care