Medication Adherence Inventory

Physician Copy

Date:_____

Patient Name:_____ **Date of Birth:**_____/_____/_____

I have reviewed the medication inventory, below, and talked with my patient about how successful he/she has been in taking medication as discussed. Currently, this patient's medication adherence falls roughly into the following category: *(Check one)*

☐ This patient reports taking all his/her medications as discussed. Medication adherence doesn't seem to be an issue at this time.

☐ This patient seems to be moderately successful in taking all of his/her medications, or has mixed adherence (takes some medications as discussed, others not). Improvement is needed.

☐ This patient seems to be nonadherent with most or all of his/her medications. Significant and immediate improvement may be needed to avoid potentially serious health consequences.

Name/Description	Schedule	How Often Taken				Reason for Not Taking Check All That Apply								
	1x day, 2x day, weekly, as needed, etc.	Every time without fail	Almost always	Most of the time	Sometimes/ hardly ever	Forget	Side effects*	Cost	Take too many pills	Don't like to take medicine	Can't get to pharmacy	Not sure why I need to take	Not filled/ refilled	Other
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														

*Please report any medication side effects to the manufacturer in question.

Please list any vitamins/supplements and the dosage you take:_____

_____

_____

_____

Recommendations:_____

AstraZeneca

Taking Stock of Your Medications

Patient Copy

Date:_____

Patient Name:_____ **Date of Birth:**_____/_____/_____

Your health is important—to you, to your loved ones, and to me as your doctor. If you're like many people, though, you may not always take your medicines as discussed, and that can put your health at risk.

Please complete the medication checklist below as completely and accurately as you can. That way, we can discuss this important part of your care openly to help ensure you make the most of your medications—and your *health*.

Getting started is easy. Simply:

- List all the medicines you take or have been asked to take by me or any other healthcare professional. Include any medicines you buy without a prescription, such as aspirin or ibuprofen. In the separate space provided, list any vitamins or supplements you take.
- If you don't know the name of a medicine, provide as many details as you can, such as the condition it's for or the color, shape, and size of the pill.

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Please list any vitamins/supplements and the dosage you take:_____

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Recommendations:_____

AstraZeneca