Medication history

OPENING THE CONSULTATION		
1	Introduces self	
2	Establishes identity of the person they are speaking to	
3	Establishes the reason for consultation	
4	Obtains consent	
MEDICATION HISTORY (ALL OF THESE QUESTIONS NEED TO BE ASKED FOR EACH MEDICATION)		
5	Identifies drug name and indication (e.g. salbutamol for asthma)	
6	Identifies how much and how often it is taken (e.g. one puff when required)	
7	Identifies medication start date (e.g. four years ago)	
8	Identifies how it is taken (e.g. inhale it quickly when breathless)	
9	Asks about adherence (e.g. only take it when required)	
10	Asks about allergies (e.g. rash to penicillin)	
SOCIAL HISTORY		
11	Asks about occupation	
12	Asks about carers e.g. parents sometimes try and remind him to take medication	
13	Asks about smoking tobacco	
14	Asks about alcohol intake	
15	Asks about recreational drug use (e.g. smokes cannabis, twice a week with friends)	
16	Asks about diet and exercise	
CLOSING THE CONSULTATION		
17	Identified pharmaceutical issue (e.g. missing doses of inhaled corticosteroids)	
18	Offers acute advice (e.g set a reminder to take it before bed and keep by the bedside)	
19	Provides long-term follow-up options (e.g. try using salbutamol before exercise)	
20	Summaries	
21	Allows patient to ask any questions	
22	Thanks patient	
KEY COMMUNICATION SKILLS		
23	Active listening	
24	Summarising	
25	Signposting	

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