Patient Name:	**NHS No:**
Allergies:	

Medication History:

Current Medication - Drug name	Dose	Frequency
Over the counter medications:		
Understands medications?	Yes/No	**Action**
Manages own medication?	Yes/No	**Action**
Carer involvement?	Details:	**Action**
Able to read labels?	Yes/No	**Action**
Able to open bottles?	Yes/No	**Action**
Able to swallow medication?	Yes/No	**Action**
Inhaler technique?	Problem	**Action**
Problem identified - trigger full medication review.		