

Current Medical Conditions: pregnant, trimester: 1 2 3
 breastfeeding, age of baby: _____

<input type="checkbox"/> anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> hypertension	<input type="checkbox"/> thyroid disorders
<input type="checkbox"/> asthma	<input type="checkbox"/> diabetes	<input type="checkbox"/> renal dysfunction	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> bronchitis	<input type="checkbox"/> epilepsy	<input type="checkbox"/> liver dysfunction	<input type="checkbox"/> ulcers
<input type="checkbox"/> CHF	<input type="checkbox"/> glaucoma	<input type="checkbox"/> malignancies	<input type="checkbox"/> urinary retention
<input type="checkbox"/> coronary artery disease	<input type="checkbox"/> gout	<input type="checkbox"/> migraine	<input type="checkbox"/> urinary frequency
<input type="checkbox"/> cerebrovascular disease	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> Parkinson's disease	

other: _____

Past History of: _____ Date diagnosed or occurred: _____

Newly Diagnosed: _____ Date: _____

Allergies: none known penicillin sulfonamide codeine other: _____

Sensitivities: none known erythromycin narcotics other: _____

Family Medical History:

<input type="checkbox"/> asthma	<input type="checkbox"/> cerebrovascular disease	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> CHF	<input type="checkbox"/> COPD	<input type="checkbox"/> hypertension	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> coronary artery disease	<input type="checkbox"/> diabetes	<input type="checkbox"/> malignancies	

other: _____
 Details: (e.g. Mother/Father still living, age of death) _____

Social History:

<input type="checkbox"/> Alcohol, average drinks per day: _____	Nutrition: <input type="checkbox"/> adequate <input type="checkbox"/> poor
<input type="checkbox"/> Caffeine intake, cup/day _____	<input type="checkbox"/> Smoking, PPD: _____
Lifestyle: <input type="checkbox"/> active <input type="checkbox"/> sedentary	<input type="checkbox"/> Other: _____

Language: English French Other: _____

Compliance Assessment:

Patient concern noted: _____

Barriers to Compliance:

none noted language literacy understanding of disease
 understanding of medication(s) forgetfulness difficulty opening vials

Intervention required:

Compliance aids: flip-cap vials (form signed) patient-filled dosette pharmacist-filled dosette

Education: disease state medication

Other: _____

Date provided/addressed: _____

Pharmacist/Assistant: _____

Drug-Related Problems and Outcomes

1- Indication for drug therapy (not receiving)
2 - Wrong drug
3 - Too little drug

4 - Too much drug
5 - ADR
6 - Drug-drug, drug-disease, drug-food, drug-herbal, drug-lab interaction

7 - Not taking/receiving prescribed drug
8 - No valid indication for drug therapy

Actual DRPs Identified:

Potential DRPs Identified:

Reason for DRPs:

Reason for DRPs:

Possible Therapeutic Alternatives for DRP (for main DRP only)

**Care Plan
Recommendations (Including Non-pharm, Action
Taken and Monitoring of Endpoints)**

**Outcome
(Details of Follow-up and/or Monitoring)**

