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**My medicines**

**Any questions or concerns?**

Please write anything you would like to discuss below

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Please complete this form about your medicines and treatments and bring it with you to your personalised care and support planning appointment.

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| **Please circle anything below that applies to you.** |
|  | I am happy with my medicines at the moment |  |
| I have difficulty getting the medicines from the surgery or pharmacy | I have difficulty in opening the packets | I have difficulty in swallowing the tablets |
| I have difficulty using cream or eye drops | I have difficulty reading labels and instructions on my medicines | I have missed or forgotten to take some medicines in the last week |
| I have needed to take extra doses of my medicine | I wish I could reduce my medicines safely  | I have concerns about my medicines |
| I wonder whether my medicines could work better | My medicine is upsetting me and I’m worried about side effects | The timing of taking my medicines is inconvenient |

**My medicines**

**Please highlight any thoughts or concerns**

|  |  |  |
| --- | --- | --- |
| **The medicines we think you are taking** | **I take this medicine at:** | **What is it for?** |
| **Breakfast** | **Lunch** | **Evening Meal** | **Bed-time** | **Other** | **Not taken** |
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| **Please add below any supplements or medicines that you buy yourself:** |