# University of Pittsburgh School of Pharmacy Patient Care Evaluation

**Background Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Date of Birth/Age |
| Address | | | |
| City | | State | Zip Code |
| Sex  Male or Female | Phone # | Occupation | |
| Living Arrangements | | | |

**Healthcare Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor’s Name  *Ex: Dr. George Franklin* | Type  *Family Physician* | Phone #  *412-555-0000* | Next Appointment  *5/24/2017* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Main Pharmacy | | Phone # | |

**Health Insurance Coverage**

|  |
| --- |
| Do you have Health Insurance? Y N  If YES, what type? Medicare Medicaid Private Adult Basic Care Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does your plan cover prescriptions?: Y N  If YES, what type? Co-pay Deductible Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If the answer is YES, stop filling this part of the form, if NO, proceed further* |
| Employment Status of Applicant: Full-time Part-time Retired Seasonal Unemployed  Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_ |
| US Citizen?: Y N |
| Family Size: Total number of people in household, including yourself: \_\_\_\_\_\_\_\_\_\_\_\_  Number of Adults: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of Children (under 18 years of age): \_\_\_\_­\_ |
| In order to ensure we are able to determine the best potential prescription assistance for you, we need to have a general range of your monthly gross income for the entire household:  Is your household income less than $31,500 for the year? Y N  If Yes, you may be eligible for PACENET  Is your household income less than $17,700 for the year? Y N  If Yes, you may be eligible for PACE  ***We will use this information to find the best prescription assistance for you*** |

**\*Shaded areas may not be relevant for standardized patients**

**Current Medications** (Include all medicines prescribed by your doctor.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name/Strength | For how long? | What is it taken for? | How is it taken?  When? (√ Check*)* | Physician | Possible Drug Therapy Problem |
| *Example:*  *Atenolol 50mg* | *2 years* | *Blood Pressure* | |  |  |  |  | | --- | --- | --- | --- | | **Morning** | **Noon** | **Evening** | **Bedtime** | | *Dr. Smith* | *Noncompliance* |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |

**Current Over-the-Counter (OTC) Medications** (Include OTC medications, vitamins, and herbal supplements.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name/Strength | For how long? | What is it taken for? | How is it taken?  When? (√ Check*)* | Physician | Possible Drug Therapy Problem |
| *Example:*  *Centrum Multivitamin* | *6 years* | *Heart Attack Prevention* | |  |  |  |  | | --- | --- | --- | --- | | **Morning** | **Noon** | **Evening** | **Bedtime** | | *Dr. Smith* | *Noncompliance* |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  |  |

**Medication Experience**

|  |  |  |
| --- | --- | --- |
| *Evaluate the patient’s* ***attitude*** *toward taking medications.* (Remember to include evidence.)  How do you feel about taking medications? | *Needs Attention in Care Plan* | |
| YES | NO |
| *Evaluate the patient’s* ***expectations*** *regarding medication use.* (Remember to include evidence.)  What do you expect or want from taking your medications? | *Needs Attention in Care Plan* | |
| YES | NO |
| *Evaluate the patient’s* ***concerns*** *regarding medication use.* (Remember to include evidence.)  What concerns do you have about taking medications? | *Needs Attention in Care Plan* | |
| YES | NO |
| *Evaluate the patient’s* ***understanding*** *of the purpose of the medications, based on the patient’s knowledge of each medication’s indication.* (Circle one.)  Good Understanding Fair Understanding Poor Understanding | *Needs Attention in Care Plan* | |
| YES | NO |

|  |  |  |
| --- | --- | --- |
| *Assess the patient’s* ***compliance*** *with medication regimens.* (Remember to include evidence.)  How often do you forget or miss a dose?  What do you do when you forget?  How does the cost of your medications affect how you take them? | *Needs Attention in Care Plan* | |
| YES | NO |
| *Evaluate presence of* ***cultural, religious, or ethical issues*** *that influence the patient’s willingness to take medications.* (Remember to include evidence.) | *Needs Attention in Care Plan* | |
| YES | NO |
| *Evaluate the patient’s* ***medication management system*** *(medication taking behaviors).* (Remember to include evidence.)  How do you manage your medications?  Where do you store your medications?  How are they organized? | *Needs Attention in Care Plan* | |
| YES | NO |

**Medication Allergies**

|  |  |
| --- | --- |
| Medication  (Name, timing, dose) | What happened?  (Nausea, rash, shortness of breath. etc.) |
|  |  |
|  |  |
|  |  |
| Other Health Alerts | Eyesight, hearing, mobility, devices, literacy, disability  (Circle all that apply or indicate NONE.) |

**Adult Immunizations**

|  |  |  |  |
| --- | --- | --- | --- |
| Immunizations | Date | Adult Immunizations | Date |
| Influenza  1 dose annually |  | Hepatitis A  2 or 3 dose series |  |
| Pneumococcal polysaccharide (PPSV23)  ≥65 yrs, chronic health condition,  1 dose for unvaccinated pts ≥1 year after PCV13, 1 dose for revaccination in 5 years |  | Hepatitis B  3 dose series |  |
| Pneumococcal conjugate (PCV13)  ≥65 yrs, immunosuppressed, HIV, renal failure, 1 lifetime dose for unvaccinated pts,  give PCV13 first; give PPSV23 ≥1 year after |  | Tetanus, diphtheria (Td)  1 booster every 10 years  Tetanus, diphtheria, and acellular pertussis (Tdap)  Substitute 1-time dose for Td |  |
| Herpes zoster (shingles)  ≥60 yrs  1 lifetime dose |  | Meningococcal  1 or more doses |  |
| Human papillomavirus (HPV)  (females <26 years; males <21 years)  2 or 3 dose series |  | Immunization schedules  <https://www.cdc.gov/vaccines/schedules/> | |

**Current Medical History**

(Please list any current medical conditions.)

|  |  |
| --- | --- |
| Medical condition | Date |
|  |  |
|  |  |
|  |  |
|  |  |

**Past Medication Use**

(Please list any medications that were once used, but are no longer and the reason for discontinuation.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication Name | Dose/Route/  Frequency/Duration | Indication | Reason for  Discontinuation | Start  Date | End  Date |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Past Medical History**

(Please list any relevant illness, hospitalizations, surgical procedures, injuries, etc.)

|  |  |
| --- | --- |
| Medical condition or recent hospitalization | Date |
|  |  |
|  |  |
|  |  |

**Family History**

|  |  |
| --- | --- |
| Family Member | Disease/Condition |
|  |  |
|  |  |
|  |  |

**Social History**

|  |  |  |
| --- | --- | --- |
| How often do you use tobacco? | How many? (√ Check*)* | When? (√ Check*)* |
| * Never | * Never |
| * 1 pack or less | * Per Day |
| * Greater than 1 pack | * Per Week |
| * Attempting to quit | * Per Month |

|  |  |  |
| --- | --- | --- |
| How often do you consume alcohol? | How many? (√ Check*)* | When? (√ Check*)* |
| * Never | * Never |
| * 1 to 3 drinks | * Per Day |
| * 4-6 drinks | * Per Week |
| * Greater than 7 drinks | * Per Month |

|  |  |  |
| --- | --- | --- |
| How often do you consume caffeine? | How many? (√ Check*)* | When? (√ Check*)* |
| * Never | * Never |
| * Less than 2 drinks | * Per Day |
| * 2-6 drinks | * Per Week |
| * Greater than 7 drinks | * Per Month |
| Other Recreational Drug Use | * Yes, type: | * No |
| Describe Diet | Meals per day? | Dietary Restrictions? |
| 1 2 3 | * Yes – religious |
| Skip Meals? Yes or No (circle) | * Yes – cultural |
| Which meal is skipped? | * Yes – health |

|  |  |  |
| --- | --- | --- |
| Describe/List Exercise | How often? (√ Check*)* | For how long? (√ Check*)* |
| * Never | * 30 minutes |
| * < 5 times per week | * 60 minutes |
| * Between 5-7 times per week | * >60 minutes |

**Recent Laboratory Work**

|  |  |  |
| --- | --- | --- |
| Laboratory test performed | Date | Results |
| *Ex: Bone Density* | *10/4/06* | *-1.0* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Physical Assessment/Other**

|  |  |  |
| --- | --- | --- |
| Height (ft/cm) | Weight (lbs/kg) | Ideal Body Weight (kg) \_\_\_\_\_\_  BMI \_\_\_\_\_\_ |
| BP \_\_\_\_\_/\_\_\_\_\_ mm Hg *(sitting)*  BP \_\_\_\_\_/\_\_\_\_\_ mm Hg *(standing)*  Heart Rate \_\_\_\_\_ | Respirations \_\_\_\_\_  Temperature \_\_\_\_\_ | ASCVD risk \_\_\_\_\_  Other \_\_\_\_\_\_ |

**Reference**

Cipolle RJ, Strand LM, Morley PC. Pharmaceutical care practice: the patient centered approach to medication management. 3rd ed. New York: McGraw-Hill; 2012.