# Questionnaire on Medication Use

Circle “YES” or “NO” below

1. Do you know WHAT medications you take? **YES or NO**
2. Do you know HOW to take your medications? **YES or NO**
3. Do you know WHY you take each medication? **YES or NO**
4. Do you know what dosage your medication is? **YES or NO**
5. Do you know how to store your medications? **YES or NO**
6. Do you know what to do if you miss a dose? **YES or NO**
7. Do you know what side effects your medications can cause? **YES or NO**
8. Do you suffer from any of these side effects? **YES or NO**
9. If so, have you mentioned these side effects to your pharmacist? **YES or NO**

If you answered **NO** to any of these questions, you should book an appointment to see your pharmacist