Your Medication Check-up

Date: __________ Time: ______________
Location: __________________________
Pharmacist Name: ___________________
Phone: (____)________________________

Reason:

☐ Cost
☐ Medical Equipment
☐ Side Effects
☐ Medical Condition(s) ______________
☐ Discharge from Hospital/Nursing Home
☐ Other __________________________

Please call at least one day before your check-up if you cannot attend.

Please bring:

• All of your medications: prescription and over-the-counter medications, inhalers, sprays, creams, etc.
• Questions about your medications and medical conditions
• Lab results or MyChart printouts
• Daily health journals (blood pressure, blood sugar, food diaries)
• Caregiver, family member or friend
• Medical Equipment (blood pressure cuff or blood glucose meter)
Your Follow-Up Appointment
Date: __________ Time: ______________
Location: __________________________
Pharmacist Name: ___________________
Phone: (____)________________________

Reason:
- Medication Changes
- New Concerns
- Continued Discussion
- Medical Condition(s)___________
- Other _________________________

Please call at least one day before your follow-up if you cannot attend.

Questions?

Please contact your local WPQC pharmacy for more information.

Visit www.pswi.org/WPQC for a complete listing of participating pharmacies.