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)