A patient/carer, when possible, is a crucial aspect of obtaining a best possible medication history. The structured approach to interviewing a patient/carer provided in this guide is intended to encourage standardisation and improve the capture of important accurate medicine information. Clinicians may need to adapt the approach used in this guide depending on circumstances.

1. Review relevant patient information
Background information about the patient’s health and social status can assist in establishing the existence of, or potential for, medication related problems.

For example, age - the younger and older patients are at most risk of medication-related problems. A patient’s age will indicate their likely ability to metabolise and excrete medicines which has implications for appropriate selection of drug and dosage.

For example, presenting condition - could their symptoms be adverse effects related to their prescribed medicines or complementary medicines? Or could lack of symptom control indicate poor adherence, inadequate dose or inappropriate agent?

Establishing this background information will allow you to identify issues to focus on during the interview, provide insight into the types of medications the patient may be taking and will assist in assessing the appropriateness of therapy (especially if your role in the patient’s care includes reviewing and/or prescribing medications).

2. Introduce yourself and explain the purpose of the interview
Provide a clear introduction to the interview. Determine the individual responsible for the administration and management of medicines, if this is the patient and they are able to communicate, confirm the time is convenient and adopt a suitable position to enable the interview to take place.

If the patient is not responsible an interview with the carer should be organised.

3. Ask about previous adverse medication events or allergies
Confirming an allergy or adverse medication event often requires more than one question as often patients do not understand what an adverse event is e.g. you might ask “…are there any medicines you are allergic to or have had a bad reaction to?”

To document an accurate and comprehensive allergy and adverse medication event history, confirm the details of any medication allergies or adverse reactions with the patient/carer and document details of the drug, reaction and date of the reaction (if known) on the medication chart and in the patient’s medical record according to hospital policy.

Comprehensive information is important as it may be used to determine whether re-exposure could be clinically appropriate when alternatives are not available.

4. Ask about prescription, non-prescription and complementary medicines
Include information about the brand, strength, form, route, dose and frequency, duration of therapy and indication i.e. why the patient thinks they are taking the medication. Remember to ask specifically about prescription, non-prescription and complementary medications.

The medication list should include recent changes to medicines including dose increase/decrease) and any recently ceased medicines. Reasons for any change should also be recorded, where known.

The medication list should include recent changes to medicines including altered medicines (e.g. dose increase/decrease) and any recently ceased medicines. Reasons for any change should also be recorded, where known.
Don’t assume that if a patient brought in a medicine that they are actually taking it.

Guide the interview responses by treating each medication separately, obtaining all information before moving onto the next medication. This reduces confusion and facilitates accurate documentation.

5. Use a checklist
Use of a checklist will improve the accuracy and completeness of the medication history. It reduces the likelihood of omitting relevant details. It prompts the patient’s memory of medications that they did not bring with them or where not brought in by the paramedics (e.g. medications stored in the refrigerator), they use on occasion only or had not perceived as a medication.

Medication History Checklist
- Prescription medications
  - Sleeping tablets
  - Inhalers, puffers, sprays, sublingual tablets
  - Oral contraceptives, hormone replacement therapy
- Non-prescription medications e.g. OTC medicines
- Complementary medications e.g. vitamins, herbal or natural therapies
- Analgesics
- Gastrointestinal medications e.g. for reflux, heartburn, constipation or diarrhoea
- Topical medications e.g. creams, ointments, patches
- Inserted medications e.g. nose/ear/eye drops, pessaries, suppositories
- Inject medications
- Intermittent medications e.g. weekly
- Recently completed courses of medication
- Social and recreational drugs
- Other people’s medicines

6. Assess patients understanding, attitude and adherence
Seek information on the patient’s:
- Understanding of rationale for treatment
- Perception of the purpose of the medicines and their effectiveness
- Perception of potential adverse effects
- Understanding of monitoring of disease/medicine.

These perceptions may impact on the patient’s adherence to prescribed treatment. To obtain honest, open responses regarding a patient’s adherence choose questions which are non-judgemental and normalise non-adherence.

Assess Adherence
- “People often have difficulty taking their medicine for one reason or another… Have you had any difficulty taking your medicine?”
- “About how often would you say you miss taking your medicine?”

7. Organise and record medicines information
It is important that the medication history is documented in a way that allows it to be readily accessed by all members of the healthcare team.

Suitable areas include the front of the National Inpatient Medication Chart, the NSW Medication Management Plan or similar form and in the electronic medical record.

The information gathered during the patient interview, as listed, should be documented clearly and succinctly. This includes the other sources of information used to clarify and validate the information obtained during the interview.

Tips
Begin with open ended questions:
- “What medicines do you take or use regardless of how you feel?”
- “What medicines do you only take or use when you need them?”
- “Do you take or use any medicines for pain/to help you with sleep/heartburn/allergies?”

Ask about medications for specific conditions identified from the medical history:
- “What medicine do you take or use for your diabetes/high blood pressure etc.?”

End with specific probing questions:
- “How often do you take or use your pain medicine?”
- “Do you take that in the morning or at night?”

Use prompts to assist the patient’s memory e.g. medication lists or patient’s own medications. Provide the patient opportunity to recall the name, how they take it and the purpose of the medicine. Do not read the list or label aloud asking if it is correct.