Hamilton Health Sciences
PATIENT EDUCATION

Michael G. DeGroote PAIN CLINIC

Medication Questionnaire

Name: _____ _____
(last name) (first name) (date)

Pharmacy: _____

Phone: _____ Fax: _____

Family Doctor: _____

Phone: _____ Fax: _____

Allergies or adverse reactions to medications:

Name of Medication	Reaction

1. Please list all medications, including over-the-counter vitamins and/or supplements you are currently taking:

Name of Medication	Dosage / Strength	Directions	Reason why you are taking it

1. List all medications (continued)

Name of Medication	Dosage / Strength	Directions	Reason why you are taking it

2. If you are taking a medication on a “when needed” basis, list the medication and give an average of pills taken in a day.

Nameof drug	Number of tablets/capsules taken in a day

3. Have you experienced any side effects from your medications?

   Yes / No (If no, go to question #5)

4. List the medications and side effect(s).

Name of Medication	Side effect(s)

5. Past medication history: What drugs have been recently discontinued or changed?

Name of Medication	Reason for being discontinued or changed

6. If you take pain medications, how many hours does it take before the pain returns?

- ❑ Pain medications does not help at all
- ❑ 1 hour
- ❑ 2 hours
- ❑ 3 to 4 hours
- ❑ Less than 12 hours
- ❑ More than 12 hours
- ❑ I do not take pain medication

7. In the last week, how much relief have pain medications provided? Place a check mark (✓) under the percentage that most describes how much relief you have received.

No relief **Complete relief**

0%	10%	20%	30%	40%	50%	60%	70	80%	90%	100%

8. Do you drink alcohol? Yes / No (If no, go to question # 9)

   How much alcohol do you consume per?

   Day _____ Week _____ Month _____

9. Do you smoke cigarettes? Yes / No (If no, go to question #10)

   (a) How many cigarettes do you smoke per day? _____

   (b) Have you quit in the past? Yes / No

   When? _____ For how long? _____

10. Do you drink caffeinated beverages (tea, coffee, pepsi, coke)?

    Yes / No If yes, how many cups or glasses per day? _____

11. Do you use street drugs? Yes / No

    If yes, what? _____

    Daily? _____ Weekly? _____ Monthly? _____