ROYAL PHARMACEUTICAL SOCIETY

Medication History

A QUICK REFERENCE GUIDE

Why this is important for you

An accurate medication history provides a foundation for assessing the appropriateness of a patient's current therapy and directing future treatment choices. It can prevent medication errors and during the process of obtaining a history other pharmaceutical issues such as poor or non-adherence can be identified. It is important, as part of your clinical role as pharmacists, that the medication histories you undertake are accurate to ensure patients' current and future therapy is safe and effective.

Who needs to read this?

This guidance is for pharmacists.

What this guidance will tell you?

This guidance provides advice on the areas pharmacists should enquire about when undertaking a medication history.

KEY POINTS

Up to date: Aim to use the most complete, reliable and up to date source(s) of information.

Cross check adherence: The medication history should be cross checked against different sources and confirmed with the patient/patient's representative. The medicines they are actually taking and how they are taking them may differ from the documentation.

Irregular medicines: Remember to ask about irregular 'when required' PRN medication such as inhalers, or medicines that are taken weekly – and the different formulations of medicines e.g. nasal sprays, ear or eye drops, ointments, depot injections, patches etc. Patients may need prompting to mention medicines such as oral contraceptives and hormone replacement therapy.

Previous medicines: The medication history should not be restricted to current therapies that a patient is taking – include any recently stopped or changed medicines.

Self selected medicines: Include any medicinal product, whether prescribed or not, and do not restrict the medication history to medicines obtained on prescription from a GP or any other source – also ask about over-the-counter (OTC) medicines, herbal products, vitamins, dietary supplements, recreational drugs including alcohol and tobacco.

Where can I obtain information when compiling a medication history?

Sources of information include:

- Patient or patient's representative
- Patient's medicines
- Repeat prescriptions
- GP referral letter
- GP surgery
- Medicine reminder charts or devices
- Hospital discharge summary or outpatient appointment notes
- Community pharmacy patient medication records
- Nursing home records
- Drug treatment centre records
- Other health care professionals and specialist clinics
- Patient medical records where available (e.g. in prisons or in Scotland access to the emergency care record)

What medicines should I enquire about?

All regular medicines but also enquire about:

- When required medicines, e.g. inhalers
- Once weekly medicines
- Any medicines that the patient has recently stopped, changed or started
- Any medicines that the patient is allergic or sensitive to or has had adverse effects with; ask about the nature and severity of the reaction

Apart from oral medicines you should also enquire about different formulations:

- Inhalers, nasal sprays, nasal drops, nebules
- Eye drops/ointments
- Regular and depot injections
- Topical creams, ointments, patches

The patient may also need prompting about other treatments such as:

- Oral contraceptives
- OTC products
- Herbal medicines
- Dietary supplements
- Recreational drugs
- Vitamins
- Hormone replacement therapy

What questions should I ask?

For each medicine determine:

- Name of the product and where appropriate, the brand name for example where bioavailability varies such as with lithium
- Dose, including both the prescribed dose and the actual dose the patient is taking. This may be best described to the patient as a quantity of tablets rather than milligram of tablet
- Strength
- Formulation e.g. phenytoin where 100mg of liquid is not equivalent to 100mg of tablet
- Route – could be an unlicensed route e.g. ciprofloxacin eye drops for the ear
- Frequency – this can also include the timings for certain medicines e.g. levodopa
- Length of therapy – if appropriate, e.g. antibiotics
- For injectables, e.g. insulin-brand and administration device
- For once weekly medicines-day of administration
- For medicines involving a variable dosing regimen, e.g. warfarin, details of the daily regimen, target level, monitoring arrangements Ask to see any patient monitoring booklets where applicable (e.g. insulin passport, methotrexate booklet, oral anticoagulant booklet)

Additional tips to consider

- Use a balance of open questions (e.g. what, how, why, when) and closed questions (requiring yes/no answers)
- Avoid jargon – keep it simple
- Explore vague responses

Where to go for further information

RPS Support: 0845 257 2570
Email **support@rpharms.com** or complete an online web form at **www.rpharms.com**

- BNF – bnf.org
- Clinical Pharmacy – www.pharmpress.com/9780853699552

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