

Multi-Med Survey

Include all medications or health related products that you are taking

Name: _____ Date of birth _____

Do you take **5 or more types** of medication per day? YES / NO

Do you take **12 or more doses** of medication per day? YES / NO

Do you take any of the following medications?

ACE inhibitor YES / NO

e.g. Apo-Captopril, Capoten, Inhibace, m-Enalapril, Prinivil, Accupril etc

Anti-epilepsy drugs / Carbamazepine YES / NO

e.g. Neurontin, Dilantin, Paxam, Tegretol etc

Digoxin YES / NO

e.g. Lanoxin etc

Diuretic (water tablets) YES / NO

e.g. Diurin, Burinex, Spirotone etc

Drugs for pain or inflammation YES / NO

e.g. Nurofen, Voltaren, Panafen, Brufen etc

Lithium YES / NO

Warfarin YES / NO

Are you currently taking medication for **3 or more health problems**? YES / NO

Have you been admitted to **hospital** in the last **3 months**? YES / NO

Do you have any **problems with your medications**? YES / NO



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