

# PRE-TEST

## Medication Management

### Georgia Elderly Nutrition Program

*Administer this questionnaire before doing “brown bag” reviews or any health education activities*

Name (ID):		County:		Date (M/D/Y):		Office Use Only
Age:	Gender: Male    Female	Race: White    Black    Hispanic    Other				
<i>Write in number here</i>						
1. How many vitamin and mineral supplements do you take?						
2. How many herbal supplements do you take?						
3. How many other non-prescription medications do you take such as aspirin, antacids, or laxatives?						
4. How many prescription medications do you take?						
<i>Circle one</i>						0 1
5. Do you go to one pharmacy for <b>all</b> of your medications?						No    Yes
6. Do you have a written list of <b>all</b> of your prescription medications, non-prescription medications, and dietary supplements?						No    Yes
7. Do you carry this written list with you in your purse or wallet?						No    Yes
8. Have you had a physician, pharmacist, or other health professional look at all of your medications in the past 6 months?						No    Yes
9. Do you <b>always</b> throw out your medications when they are expired (past their “use by” date)?						No    Yes
10. Do you <b>use</b> a pillbox or other system to help you take your medications?						No    Yes
11. Do you know the name of <b>each</b> of your medications?						No    Yes
12. Do you know what <b>each</b> of your medications is for?						No    Yes
13. Do you know the time of day to take <b>each</b> of your medications?						No    Yes
14. Do you know whether to take <b>each</b> of your medications on an empty stomach or with food?						No    Yes
15. Do you know the possible side effects of <b>each</b> of your medications?						No    Yes
16. Do you know how to store <b>each</b> of your medications (e.g., in the medicine cabinet or in the refrigerator)?						No    Yes
<b>Total “no” answers:</b>						
<i><b>If you answered “no” to any of the above questions, then talk with your pharmacist, physician or other health professional to learn more about your medications.</b></i>						

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**Post-Test**  
**Medication Management**  
**Georgia Elderly Nutrition Program**  
*Administer this questionnaire after doing “brown bag”  
 reviews AND all of the health education activities*

Name (ID):		County:		Date (M/D/Y):		Office Use Only
Age:	Gender: Male    Female	Race: White    Black    Hispanic    Other				
						<i>Write in number here</i>
17. How many medication management lessons did you attend? <b>(Document with attendance records).</b>						
18. How many vitamin and mineral supplements do you take?						
19. How many herbal supplements do you take?						
20. How many other non-prescription medications do you take such as aspirin, antacids, or laxatives?						
21. How many prescription medications do you take?						
						<i>Circle one</i>
22. Do you go to one pharmacy for <b>all</b> of your medications?						0 1
22. Do you go to one pharmacy for <b>all</b> of your medications?						No    Yes
23. Do you have a written list of <b>all</b> of your prescription medications, non-prescription medications, and dietary supplements?						No    Yes
24. Do you carry this written list with you in your purse or wallet?						No    Yes
25. Have you had a physician, pharmacist, or other health professional look at all of your medications in the past 6 months? <b>(Staff should document with attendance records).</b>						No    Yes
26. Do you <b>always</b> throw out your medications when they are expired (past their “use by” date)?						No    Yes
27. Do you <b>use</b> a pillbox or other system to help you take your medications?						No    Yes
28. Do you know the name of <b>each</b> of your medications?						No    Yes
29. Do you know what <b>each</b> of your medications is for?						No    Yes
30. Do you know the time of day to take each of your medications?						No    Yes
31. Do you know whether to take <b>each</b> of your medications on an empty stomach or with food?						No    Yes
32. Do you know the possible side effects of <b>each</b> of your medications?						No    Yes
33. Do you know how to store <b>each</b> of your medications (e.g., in the medicine cabinet or in the refrigerator)?						No    Yes
<b>Total “no” answers:</b>						
<i><b>If you answered “no” to any of the above questions, then talk with your pharmacist, physician or other health professional to learn more about your medications.</b></i>						