UCLA Health System

Your Name:

Date of Birth:

Pre-Transplant Medication List

PHARMACY INFORMATION (Please list the name, address and telephone number of any pharmacy that you have used to fill prescription medications in the last six months. If you use more than 2 pharmacies, please include the information for the other pharmacies at the end of this document under "Other Issues"):

Pharmacy #1
Name:_____
Address: _____
_____
Telephone #:_____

Pharmacy #2
Name:_____
Address: _____
_____
Telephone #:_____

ALLERGIES (please list any known allergies – write the name of the medication and the reaction you had when taking it):

We want to assess the medications that you are currently taking. Please complete the tables below including all of your Prescription Medications (Prescribed tablets, capsules, inhalers, injections, eye drops, etc.), Non-Prescription Medications (over-the-counter tablets, capsules, inhalers, eye drops, etc.) and Dietary/Nutritionals Supplements & Complementary and Alternative Medications (over-the-counter vitamins, herbs, supplements, etc.)

PRESCRIPTION MEDICATIONS (Please list medications that you currently take that were prescribed by a caregiver):

Name of Medication	**Dosage**	**Directions**
Example: *Renvela*	*800 mg*	*Three times a day with meals*

NON-PRESCRIPTION MEDICATIONS (Please list any non-prescription medications that you take on a daily or as needed basis – this may include the use of cough and cold medications, pain relievers, antacids, laxatives, sleeping pills, etc.):

Name of Medication	**Dosage**	**How do you use this medication?**	**Reason for taking this medication**	**If used as needed, how often do you take it per week**
Example: *Tylenol*	*325 mg*	*Only as needed*	*Taken when I have a headache or fever*	*Once or twice a week*

DIETARY/NUTRITIONAL SUPPLEMENTS and/or COMPLEMENTARY AND ALTERNATIVE MEDICATIONS
(Please list any dietary/nutritional supplements or alternative and complementary medications that you take on a daily or as needed basis):

Name of Supplement	**Dosage**	**How do you use this supplement?**	**Reason for taking this supplement**	**If used as needed, how often do you take it per week**
Example: *Omega-3*	*1 capsule*	*Three times a day*	*Good for my heart*	

We would like for you to tell us about how you take your medications and whether you have any problems with taking or obtaining your medications. Please read the questions listed below and put an "X" in the box that best describes your answer to the question.

	None of the time	**Some of the time**	**Most of the time**	**All of the time**	**Don't know**
1. How often do you forget to take one or more of your prescription medications?					
2. Have you ever decided not to take one or more of your prescription medications (maybe because it causes side effects, is too expensive, etc.)?					
3. Have you ever run out of one or more of your prescription medications before getting a new refill (either from the pharmacy or your caregiver)?					
4. When you feel good, do you sometimes stop taking one or more of your prescription medications (maybe because you feel they are unnecessary or they will make you feel worse)?					
5. When you don't feel good, do you sometimes stop taking one or more of your prescription medications (maybe because you feel that they will make you feel worse or are not helping)?					
6. Have you ever used a friend, family member or co-worker's medications (maybe because you don't have yours available or they tell you how good their medication works)?					
7. Have you ever had difficulty affording your prescription medications (maybe because you can't afford the co-pay, or it is not covered by your insurance, etc.)?					
8. Has your pharmacy had difficulty filling your prescription medications (maybe because they don't have the medication in stock or they don't have enough to fill your prescription completely, etc.)?					

OTHER ISSUES (please list any other issues you may have with medications that you have not already listed previously):