Name: ______________________DOB:_________ Date:_______

BRIEF GOAL CHECK (BGC) – Follow-up Visits 2-6

A. Medication Update (Use extra page if needed)			
1. What medications are you taking for your BP? **LIST DRUGS HERE ►**	**Drug 1** ________________	**Drug 2** ________________	**Drug 3** ________________
2. How did you take this drug in the past week? (If none, write '0'.)	Took __ time(s) a day	Took __ time(s) a day	Took __ time(s) a day
3. How many times did you miss it in the last 7 days? (If none, write '0'.)	Missed __ times	Missed __ times	Missed __ times
4. Does it bother you in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. What concerns or problems are you having with it? (If none, write '0'.)			

B. Changes since your last pharmacy visit

1. Has there been any change in your health since your last visit? ☐ Yes ☐ No
2. Have you made any changes in your use of medication, physical activity, or what you eat? ☐ Yes ☐ No

C. BP	BP last visit:	BP today: _________Staff initials: _____	**BP at goal?** ☐ Yes ☐ No

D. Pharmacist Assessment and Plan

Counseled regarding:	
☐ BP ☐ Adherence ☐ Barriers to adherence: ☐ Lifestyle ☐ Patient goals ☐ Other	☐ Patient will return for BP monitoring _____________ ☐ Patient referred to doctor for evaluation ☐ Report will be sent to prescriber ☐ Other
Pharmacist Signature	Level of BP Follow-up: ☐ none ☐ 1-3 min ☐ 4-6 min

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