Name: _____ **ID** _ _-_ _ **Date:** _____

Brief Medication Questionnaire (BMQ) – Initial Visit

This form will help us assess how your medications are working for you. **Please <u>circle</u> the number that describes your experience with each drug. Use extra page if needed.**

1. What medications do you currently take for your blood pressure? LIST DRUGS HERE ►	**Drug 1**	**Drug 2**
2. How does your doctor want you to take this drug?	1 every day 2 as needed 3 don't know	1 every day 2 as needed 3 don't know
3. How is this drug supposed to help you? **(CIRCLE ALL THAT APPLY)**	1 get rid of water 2 lower my pressure 3 prevent a stroke 4 prevent heart problem 5 relieve headaches 6 other _____ 7 don't know	1 get rid of water 2 lower my pressure 3 prevent a stroke 4 prevent heart problem 5 relieve headaches 6 other _____ 7 don't know
4. IN THE PAST WEEK… a. how many <u>days</u> did you use this drug? …… b. how many <u>times a day</u> did you use it? …… c. how much did you use <u>each time</u>? …… d. how many times did you MISS taking it? …… **(If none, circle '0')**	 0 1 2 3 4 5 6 7 days 0 1 2 3 time(s) a day 0 ½ 1 2 3 pill(s) 0 1 2 3 4 5 6 7 time(s)	 0 1 2 3 4 5 6 7 days 0 1 2 3 time(s) a day 0 ½ 1 2 3 pill(s) 0 1 2 3 4 5 6 7 time(s)
5. How well does this drug work for you?	0 not at all well 1 moderately well 2 very well 3 don't know	0 not at all well 1 moderately well 2 very well 3 don't know
6. Does this drug bother you in any way?	0 No 1 Yes	0 No 1 Yes
7. What kinds of concerns or problems are you having with it? If none, write '0'		
8. How much difficulty are you having in each area? a. It is hard to remember all the doses…… b. It is hard to pay for this drug…… c. It is hard to get my refill on time…… d. I still get unwanted side effects from this drug…… e. I worry about the long term effects of this drug… f. This drug causes other concerns or problems……	<u>None A little A lot</u> 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2	<u>None A little A lot</u> 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2

9. Have you had any of the following problems in the past 30 days? Check all that apply to you.

☐ Dizziness	☐ Feeling depressed	☐ Numb/tingling hands	☐ Less interest in sex
☐ Headaches	☐ Frequent thirst	☐ Leg pain or swelling	☐ Unable to get erection
☐ Shortness of breath	☐ Frequent urination	☐ Leg cramps	☐ Difficulty sleeping
☐ Feeling tired	☐ Dry mouth	☐ Cold hands or feet	☐ Rash or hives
☐ Thumping/racing heart	☐ Loss of taste	☐ Difficulty breathing	☐ Constipation
☐ Feel weak when I stand	☐ Blurry vision	☐ Dry, hacking cough	☐ Diarrhea
►Are any of these problems caused by your blood pressure medication? ☐ No ☐ Yes ☐ Don't know			

10. Do you take any other medications for your blood pressure? If yes, please list other drugs here ►	**Drug 3**	**Drug 4**
11. How does your doctor want you to take this drug?	1 every day 2 as needed 3 don't know	1 every day 2 as needed 3 don't know
12. How is this drug supposed to help you? **(CIRCLE ALL THAT APPLY)**	1 get rid of water 2 lower my pressure 3 prevent a stroke 4 prevent heart problem 5 relieve headaches 6 other _____ 7 don't know	1 get rid of water 2 lower my pressure 3 prevent a stroke 4 prevent heart problem 5 relieve headaches 6 other _____ 7 don't know
13. IN THE PAST WEEK… a. how many <u>days</u> did you use this drug? …… b. how many <u>times a day</u> did you use it? …… c. how much did you use <u>each time</u>? …… d. how many times did you MISS taking it? …… **(If none, circle '0')**	 0 1 2 3 4 5 6 7 days 0 1 2 3 time(s) a day 0 ½ 1 2 3 pill(s) 0 1 2 3 4 5 6 7 time(s)	 0 1 2 3 4 5 6 7 days 0 1 2 3 time(s) a day 0 ½ 1 2 3 pill(s) 0 1 2 3 4 5 6 7 time(s)
14. How well does this drug work for you?	0 not at all well 1 moderately well 2 very well 3 don't know	0 not at all well 1 moderately well 2 very well 3 don't know
15. Does this drug bother you in any way?	0 No 1 Yes	0 No 1 Yes
16. What kinds of concerns or problems are you having with it? (If none, write '0')		
17. How much difficulty are you having in each area? a. It is hard to remember all the doses…… b. It is hard to pay for this drug…… c. It is hard to get my refill on time…… d. I still get unwanted side effects from this drug…… e. I worry about the long term effects of this drug… f. This drug causes other concerns or problems……	 <u>None A little A lot</u> 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2	 <u>None A little A lot</u> 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2 0 1 2

Thank you!