LMQ

Living with Medicines Questionnaire

Medicines and Your Day-to-Day Life

This questionnaire seeks **your** views and opinions about the prescribed medicines **you** take and how they affect **your** life.

Medicines include tablets, creams, inhalers, liquids and so on.

This booklet contains statements which cover different aspects of using medicines.

Please read each statement carefully and tick the response box that is closest to your personal opinion. Please tick only one box for each statement.

Medicines and Your Day-to-Day Life – Living with Medicines Questionnaire

Please tick the option that applies to each of the statements.

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
1.	The instructions on my medicines are **easy** to follow.	☐	☐	☐	☐	☐
2.	I find getting my prescriptions from the doctor **difficult.**	☐	☐	☐	☐	☐
3.	I find getting my medicines from the pharmacist **difficult.**	☐	☐	☐	☐	☐
4.	My medicines are **important** to me.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
5.	I find opening the packaging of my medicines **difficult.**	☐	☐	☐	☐	☐
6.	I am **concerned** about running out of medicines.	☐	☐	☐	☐	☐
7.	It is **difficult** to identify which medicine is which.	☐	☐	☐	☐	☐
8.	It is **easy** to keep to my medicines routine.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
9.	I would be **concerned** if I forgot to take my medicines.	☐	☐	☐	☐	☐
10.	I am **concerned** that I may forget to take my medicines	☐	☐	☐	☐	☐
11.	I am **concerned** about experiencing side effects.	☐	☐	☐	☐	☐
12.	I am **concerned** about possible damaging long term effects of taking medicines.	☐	☐	☐	☐	☐
13.	Taking medicines is **routine** for me.	☐	☐	☐	☐	☐

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Please tick the option that applies to each of the statements.

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
14.	I am **comfortable** taking the medicines I have been prescribed.	☐	☐	☐	☐	☐
15.	I am **comfortable** with the times I should take my medicines.	☐	☐	☐	☐	☐
16.	I find the patient leaflet in my medicines containers **useful**.	☐	☐	☐	☐	☐
17.	I find using my medicines **difficult.**	☐	☐	☐	☐	☐
18.	I am **satisfied** with the effectiveness of my medicines.	☐	☐	☐	☐	☐
19.	I am **concerned** that I am too dependent on my medicines.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
20.	I am **confident** speaking to my doctor(s) about my medicines.	☐	☐	☐	☐	☐
21.	I **understand** what my doctor(s) tell me about my medicines.	☐	☐	☐	☐	☐
22.	The information my doctor(s) gives me about my medicines is **useful**.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
23.	I am **confident** speaking to my pharmacist about my medicines.	☐	☐	☐	☐	☐
24.	I **understand** what my pharmacist tells me about my medicines.	☐	☐	☐	☐	☐
25.	The information my pharmacist gives me about my medicines is **useful**.	☐	☐	☐	☐	☐

Please Turn Over

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Please tick the option that applies to each of the statements.

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
26.	I sometimes run out of medicines.	☐	☐	☐	☐	☐
27.	I accept that I have to take medicines long term.	☐	☐	☐	☐	☐
28.	My medicines allow me to live my life as I want to.	☐	☐	☐	☐	☐
29.	My life revolves around using my medicines.	☐	☐	☐	☐	☐
30.	My medicines live up to my expectations.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
31.	My medicines prevent my condition getting worse.	☐	☐	☐	☐	☐
32.	Taking medicines interferes with my social life.	☐	☐	☐	☐	☐
33.	I trust the judgement of my doctor(s) in choosing medicines for me.	☐	☐	☐	☐	☐
34.	I have to put a lot of planning and thought into taking my medicines.	☐	☐	☐	☐	☐
35.	Taking medicines causes me problems with daily tasks (such as work, housework, hobbies).	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
36.	I am unhappy with the extent to which my medicines interact with alcohol.	☐	☐	☐	☐	☐
37.	Taking medicines affects my driving ability.	☐	☐	☐	☐	☐
38.	I worry that I have to take several medicines at the same time.	☐	☐	☐	☐	☐
39.	The side effects I get are worse than the problem for which I take medicines.	☐	☐	☐	☐	☐
40.	I worry that my medicines may interact with each other.	☐	☐	☐	☐	☐

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Please tick the option that applies to each of the statements.

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
41.	I can choose whether or not to take my medicines.	☐	☐	☐	☐	☐
42.	My doctor(s) spend enough time discussing my medicines with me.	☐	☐	☐	☐	☐
43.	I know enough about my medicines.	☐	☐	☐	☐	☐
44.	I am able to balance my day to day life with taking medicines	☐	☐	☐	☐	☐
45.	There is enough sharing of information about my medicines between the different health professionals providing my care.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
46.	I have a say in the brands of medicines I use.	☐	☐	☐	☐	☐
47.	I always follow my doctor(s) advice about my medicines.	☐	☐	☐	☐	☐
48.	I sometime feel I need to get information from other sources (such as books, friends, internet).	☐	☐	☐	☐	☐
49.	I can change the times I take my medicines if I want to.	☐	☐	☐	☐	☐
50.	The health professionals providing my care know enough about me and my medicines.	☐	☐	☐	☐	☐

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
51.	My medicines are working.	☐	☐	☐	☐	☐
52.	I can adapt my medicine-taking to my lifestyle.	☐	☐	☐	☐	☐
53.	My doctor(s) listen to my opinions and concerns about my medicines.	☐	☐	☐	☐	☐
54.	I can vary the dose of the medicines I take.	☐	☐	☐	☐	☐
55.	I get too much information about my medicines.	☐	☐	☐	☐	☐

Please Turn Over

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Please tick the option that applies to each of the statements.

		Strongly agree	Agree	Neutral opinion	Disagree	Strongly disagree
56.	Changes in daily routine cause problems with my medicines.	☐	☐	☐	☐	☐
57.	My doctor(s) takes my concerns about side effects seriously.	☐	☐	☐	☐	☐
58.	My medicines have an adverse effect on my sexual life.	☐	☐	☐	☐	☐
59.	The side effects are worth it for the benefits I get from my medicines.	☐	☐	☐	☐	☐
60.	The medicines I use have an adverse effect on the holidays I can take.	☐	☐	☐	☐	☐

If you have any other views about how your medicines affect your day-to-day life, please describe them here.

Finally, please answer a few questions about you and your medicines

Are you: Male ☐ Female ☐

What is your age? 18-29 ☐ 30-49 ☐ 50-64 ☐

65-74 ☐ 75-89 ☐ over 90 ☐

Which ethnic group best describe you? *(Please tick **one** box only)*

White ☐ Mixed ☐ Asian or Asian British ☐

Black or Black British ☐ Chinese ☐ Other ☐ ……

What is the highest level of education you have completed?

None ☐ Primary/ Few years secondary ☐

Secondary completed ☐ College/Further education ☐

Bachelor degree ☐ Higher degree ☐

Still studying ☐ *(Please tell us what level are you in)*

……

How many medicines do you take regularly? less than 4 ☐ between 4 and 8 ☐ more than 8 ☐

<u>Medicines include tablets, creams, inhalers, liquids and so on.</u>
<u>Count each different prescription as one medicine.</u>

What is your employment status? Employed ☐ Unemployed ☐ Retired ☐

Do you pay for your prescriptions? Yes ☐ No ☐

Does someone help you with using your medicines? Yes ☐ No ☐

If you answered yes, who helps you? Spouse/Partner ☐ Relative ☐ Other ☐

If you answered other, please write here who helps you. _____

Thank you for taking the time to complete this questionnaire.