Medication Adherence Safety Compliance Questionnaire

Dear [Patient's Name],

We are committed to ensuring your health and safety. To help us understand your medication adherence, please take a moment to fill out the questionnaire below:

Name of Medication:

Dosage Frequency:

On a scale of 1-5, how would you rate your adherence to this medication?
1 - Not at all 2 - Rarely 3 - Sometimes 4 - Often 5 - Always

Have you experienced any side effects while taking this medication?

Additional Comments:

Thank you for your cooperation.

Sincerely,

[Your Organization Name]