



PATIENT MEDICATION LIST

Person Completing Form (print name):	PATIENT OR FAMILY: Please list all medications you are currently taking. Include all prescription medications, over the counter medications, supplements, eye drops, and or herbals.									
□ No Medications □ Unable to obtain history, reason: □ No Known Allergies to drugs and reaction, food and reaction, and if allergic to latex: Vaccine/Date: Vaccine/Date: Vaccine/Date: □ Influenza va						Relationship to Patient:				
Distallergies to drugs and reaction, food and reaction, and if allergic to latex:										
□ Pheumonia vaccine/Date: □ Influenza vaccine/Date: □ Rhogam/Date: □ Rhogam/Date	□ No Known	List Allergies to drugs and reaction, food and reaction, and if allergic to latex:								
frequency is available, it may be included but is not required. Prioperative surgical patients require date, time, amount and route of last dose for medications such as beta blockers, and antibiotics. This must be recorded prior to the procedure. MEDICATION NAME: (WRITE LEGIBLY) Attach to form: Patient list Facility list Dose (mg, mcg, other) Coral, other) Coral, other) Coral, other FOR HOSPITAL USE ONLY Information Source (circle): Patient Family MD List Container Pharmacy EMS Other: For any updates, complete and attach additional PATIENT MEDICATION LIST List Reviewed by (print name): Date: Time: MEDICATIONS AT DISCHARGE: *OUTPATIENT ONLY* PATIENT IS ADVISED TO REEP AN UPDATED HOME MEDICATION LIST ON HAND TO SHARE BITH PHISTICAN(S) Copy of medication prescriptions placed in medical record, originals to patient MAND TO SHARE BITH PHISTICAN(S) New medication at discharge, change in prior medication prescribed, or special instructions: AT EACH OFFICE VISIT MEDICATIONS AT DISCHARGE: Dose Route Frequency Instructions, if applicable Patient/Family/Power of Attorney Signature: Dose Physician/LIP/Pharmacist Signature/Authentication: Signature/Authenticatio										
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