# Medication Reconciliation Assessment History Form

Patient Name: Date of Birth: Visit Date:

| ALLERGIES (To be completed by Patient) | | |
|---|---|---|
| No Known Drug Allergies | | Latex: No Yes- Reaction:<br>IV Contrast: No Yes- Reaction:<br>Food: No Yes- Reaction:<br>Environment: No Yes- Reaction:<br>Other (Please Specify): |
| MEDICATIONS | REACTION | |
| | | |
| | | |
| | | |
| | | |
| HEIGHT: | WEIGHT: lbs | |

List all medications that you are currently taking, including non-prescription, vitamins, and herbal products. (No Attachments Please)

No Medications

| To be completed by Patient | | | | | To be completed by Physician | |
|---|---|---|---|---|---|---|
| **Medications** | **Dose** | **Route** (PO, SC, IV, etc.) | **Frequency** | **Last Dose Taken** (Complete on day of procedure) | **Action** | **Comments** |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |
| | | | | | Resume<br>Discontinue | |

Completed By: Patient/Family Member; Physician Office Records; Patient Medication Bottles/List; Facility Medication Record; Pharmacy; Other

| NEW AND MODIFIED MEDICATIONS (To be completed by Physician) | | | | |
|---|---|---|---|---|
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** |
| | | | | |
| | | | | |
| | | | | |

ALL new medication orders are to be written on prescription

| Date | Signature of Nurse Obtaining Medication History: | Date | Signature of Discharging Physician: |
|---|---|---|---|
| | | | |

Patient Label