PATIENT NAME:_____ DOB:_____

PHARMACY NAME:_____ LOCATION:_____

MEDICATION RECONCILIATION/ALLERGY FORM

ALLERGIES: Y N (LIST ALL MEDICATION ALLERGIES & REACTIONS INCLUDING LATEX)

MEDICATION/REACTION	MEDICATION/REACTION

MEDICATIONS PRIOR TO ADMISSION: (List all medications, including OTC drugs, Herbal supplements)
_____Patient takes NO medications, OTC drugs or dietary supplements on a routine basis.

Medication (RN check if taken today)	Dose / Frequency	Unknown (Check here)	Indication (Reason)
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○		○	
○ BLOOD THINNERS (including Aspirin)		○	
○		○	
○		○	

ATTESTATION: The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs.

Patient/Guardian Signature:_____ **Date:**_____