Name: ______________________________

DOB: ______________

OUTPATIENT MEDICATION RECONCILIATION

Allergies	**Reaction**
FOOD	
ENVIRONMENT	
MEDICATION	

Immunization History:

Tetanus	☐Yes	☐No	Date: ________
Pertussis	☐Yes	☐No	Date: ________
Hepatitis B	☐Yes	☐No	Date: ________
Pneumovax	☐Yes	☐No	Date: ________
Influenza	☐Yes	☐No	Date: ________

☐ Not Sure

Please list all medication(s) you are currently taking, including herbal, supplements, and non-prescription over-the-counter medications:

Today's Date	Medication Name	Dosage (mg, mcg)	How Taken (pill, elixir…)	Frequency	Last dose (date/time)	Prescribing Physician

Would you like to have this list sent to other medical providers? ☐Yes ☐No

If "Yes", to whom? ____

THIS SECTION OFFICE USE ONLY:
New Medications to take following this visit and any changes to medications listed above:

Today's Date	Medication Name	Dosage (mg, mcg)	How Taken (mouth, IV…)	Frequency	Last dose (date/time)	Prescribing Physician

Medications reviewed and/or updated on these Dates:

Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Date: ________	Date: ________	Date: ________	Date: ________	Date: ________
Date: ________	Date: ________	Date: ________	Date: ________	Date: ________