Patient Home Medication List-as provided by the Patient

Name _____ Date _____

*Attention patients - please contact your primary care doctors if you have questions on resuming any of your regular routine home medications. Keep this list and take it with you to your future healthcare providers following your visit here.

ALLERGIES/Reactions

_____

_____

_____

Medication Name	Dose	Route	Frequency	Reason for taking	Last taken (date/time)	Continue	Discontinue

*Will any prior medications be discontinued or altered? yes no
*Should any prior medication be held, pending consultation with the prescriber? yes no
*Have any new prescriptions been added today? yes no

New Prescriptions

Medication Name	Dose	Route	Frequency	Reason for taking	Begin	Continue	Discontinue

Home medications list and allergies reviewed:

_____ _____
Physician Date

_____ _____
Witness-RN Date

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