Medication History Form

Patient:_____Bed #_____Date of Birth:_____

A) Check in with nurse (or chart) and ask if he/she has a medication list
B) Wash hands
C) Verify patient name/date of birth, introduce yourself and why you are there
D) Verify allergies in the computer are accurate and up-to-date. Obtain any missing information.
E) Ask the patient if he/she has a medication list
F) Ask if the patient knows what medications he/she is taking (if not, obtain pharmacy/nursing home, or MD office and location:_____)

Is anyone at home who can answer questions about your medications? _____ **phone** _____
Which pharmacy do you use? _____ **phone** _____
Who is your primary doctor? _____ **phone** _____
Is it OK if I call your home, pharmacy or doctor if I need more information?

Obtain medications and last date/time taken

Medication	Strength	Route	Directions	Prn or Routine	Last date/time taken

G) Ask if the patient uses any of the following:

	Yes	No		Yes	No
Vitamins:	☐	☐	Injections:	☐	☐
Antibiotics:	☐	☐	Creams/Oint/Lotion	☐	☐
Supplements/herbals:	☐	☐	Anything for sleep:	☐	☐
Aspirin:	☐	☐	Birth control (female)	☐	☐
OTC for pain:	☐	☐	Male enhancement:	☐	☐
Other OTC:	☐	☐	Eye or ear meds:	☐	☐
Inhalers/Nose sprays:	☐	☐	Medication samples:	☐	☐
Patches:	☐	☐	Investigational meds:	☐	☐

H) Recent vaccinations?
   a. Flu, When?
   b. Pneumonia, when?

I) Ask if there is anything else they can think of, thank the patient, ask if they need anything (can refer to nurse/patient care technician, wash hands).