**MEDICATION RECONCILIATION**

**Please list all medications you are currently taking including over-the - counter, herbal medicine, home remedies, eye drops and vitamins.**

| **Medication Name** | **Dose** (How many mg, mcg?) | **Route** (Mouth, eye, nose) | **How often?** (Daily, 2 times a day) |
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**ALLERGIES**:

| **Medication** | **Type of Reaction** | **When** |
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***Are you allergic to latex?*** □ ***Yes*** □ ***No***
***Are you allergic to betadine?*** □ ***Yes*** □ ***No***
**►Have you have a newly diagnosed medical problem or illness in the last 30 days?**
**Explain:**_____
_____

**Patient Sign Here:**_____**Date:**_____

**Reviewed By:**_____**Date:**_____

**Name of Pharmacy:**_____**Phone #:**_____