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)

ALLERGIES:

Medication	**Type of Reaction**	**When**

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 #:**_____