# Patient Medication History Form

The medicines you take are part of your health information. Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. If you need more space to list your medicines, ask for another form. Please do not write on the back of this form.

Patient Name: ___________________________ Page #: ________

## Allergies

<table>
<thead>
<tr>
<th>Name of Substance (drug or food)</th>
<th>Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing, etc.?  
☐ Yes  ☐ No

For female patients ONLY:
- Are you currently pregnant?  
  ☐ Yes  ☐ No
- Are you considering becoming pregnant?  
  ☐ Yes  ☐ No
- Are you currently breastfeeding?  
  ☐ Yes  ☐ No

## Current Medications

### Prescription Drugs  
(such as Atenolol, eye drops, creams)

<table>
<thead>
<tr>
<th>Strength (such as 50 mg)</th>
<th>Directions (such as 2 tablets in the a.m.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check box if taken only as needed.</td>
</tr>
</tbody>
</table>

☐ Check if none

### Over-the-Counter Medications  
(such as aspirin)

<table>
<thead>
<tr>
<th>Strength</th>
<th>Directions (such as for headaches, when needed)</th>
</tr>
</thead>
</table>

☐ Check if none

### Herbs, Vitamins, Minerals, Etc.  
(such as St. John’s Wort)

<table>
<thead>
<tr>
<th>Strength</th>
<th>Directions (such as one tablet each day)</th>
</tr>
</thead>
</table>

☐ Check if none

Pharmacy Name: ___________________________ Phone #: ___________________________

## STAFF ONLY

☐ Medication list reviewed prior to any change/deletion/addition by licensed provider

☐ Yes – Pre-Surgery (Yellow) Packet or Return clinic visit within one week?