Provided by: Trivergent Health Alliance

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:_____)

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:

Recent antibiotics:
Vitamins:
Supplements/herbals:
Aspirin:
OTC for pain:
Other OTC:
Inhalers:
Topicals (cream/patch sprays):
Eye/ear drops:
Injections:
Anything for sleep:
Birth control/hormone replacement (female):
Male enhancement:
Investigational meds:
Medication samples:
Sharing medications with anyone:
Nutritional Supplements:

H) 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).