

## Medication Reconciliation Patient Questionnaire

❖ Drug reactions

Name of Medication	Reaction	Treatment to resolve reaction

Please list ALL substances that were non-food or drink items consumed in the last 30 days.

❖ Prescription Medications: including inhalers, radiology contrasts, blood, IV solutions, eye drops, as needed medications

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

❖ Over the Counter Medications: i.e. Cold/Flu, pain, headache, vitamins, diet related, sleep aids, stomach, diarrhea, constipation, sinus

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

❖ Sports/Dietary Supplements & Herbals: i.e. pills, powders, gels, teas, drinks, creams

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

Print Name: \_\_\_\_\_  
 Date of Appt: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
 Please use reverse side for additional listings