Outpatient Medication History Form- please read instructions on back of form prior to filling out

☐ **Source of Medication List:** _____ ☐ **NO HOME MEDICATIONS** ☐ **Unable to obtain medication history [give reason and follow-up plan (i.e. family bringing in)]:**	☐ **NO KNOWN ALLERGIES** **ALLERGIES (medications, food, vaccines, latex, dyes, etc.):** **DESCRIBE REACTION or ALLERGY:**
Primary Care Physician:	
Patient's Home Pharmacy:	

Medications on Admission

INSTRUCTIONS: Include prescriptions, over-the-counter medications, patches, inhalers, vitamins, herbal/home remedies, teas, dietary supplements.

Medication [Include dosage form if indicated (EC, XL, ER, SR, CD, XR)]:	**Dose** (amount)	**Route** (oral, topical, inject, etc.)	**Schedule** (how often you take the med)	**When Last Taken** Date	Time	**Reason for taking (e.g.diabetes, Hypertension, etc.)**	**Medication Started**	**Medication Discontinued**

BELOW FOR STAFF USE ONLY

☐ Copy to patient at time of discharge from service with instructions to keep with them and share with other healthcare providers. Date _____

DO NOT REMOVE ORIGINAL FROM THE CHART

MEDICATION REVIEW DATES

Date / Time	Signature	Date / Time	Signature	Date / Time	Signature	Date / Time	Signature

Stamp Plate

Intermountain Healthcare

Outpatient Medication History Form

Part 1: Medical Records Part 2: Pharmacy Part 3: Patient

Med His 50225

1A 1B PROOF 2 8110051633

FACE 1-3; SCREENS 10% 50% & 20%

Outpatient Clinic Medication History Form- Please read instructions prior to filling out

Instructions

- Please NOTE that this is an outpatient medication history form that will be used to keep track of current medications you may be taking.
- A different form is used for inpatient settings.
- This form can serve as a template medication history if admitted to a health care facility.

Patient or Caregiver

1. Please list medications with attention to the entire description. (e.g., note if XR, SR, XL. are at the end of the medication name). This information can be found on your prescription labels.
2. Please include any medications you are currently prescribed but not taking.
3. Please indicate reasons why not taking these medications.
4. At discharge from this service please keep this with you and share with other Healthcare providers.

Nurse/Clinical Educator

1. Review the completed Medication History Form with patient and family as part of the overall history.
2. This form may be used to supplement current history forms; if current history forms have a medication section, please write “see medication history form.”
3. Sign in the "reviewed by" signature block.
4. Cross through medications that are discontinued.
5. Contact the practitioner and any related pharmacy services if any compliance issues are noted.

Unit Coordinator/Secretary/Clerical

1. Make sure the form has been reviewed and signed by the nurse.
2. Place the original form in the patient’s chart in the designated section.

Pharmacist

1. If requested by the outpatient facility, please reconcile medications reviewing for duplicate therapies, incorrect dosing, scheduling, etc.
2. If problems are noted, document in the Medical Record. Please initial any entries on the form.
3. Contact the practitioner directly if compliance issue(s) impact patient care.

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