

Medication List and Reconciliation Form

Patient Name: _____ DOB: _____

Allergies: No, I do not have any drug allergies.
 Yes, I do have drug allergies: _____

Prescription and Non-Prescription Medications:

- No, I do not take any medications.
- Yes, I do take medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

The above information is accurate to the best of my knowledge. I understand that I need to consult my primary care physician for any changes to my medications.

Patient signature: _____ Date: _____