Patient Name	Date of Birth	Height _____ WEIGHT: _____lbs = _____ KG

Source of medication list: ❑ Patient medication list ❑ Patient/family recall ❑ Other _____

❑ **NO KNOWN ALLERGIES** **NOTE:** If Allergies exist, list all allergies and reactions including medications, foods and latex.

ALLERGY	REACTION	ALLERGY	REACTION

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS INCLUDING
Over-the-counter, herbal medications, inhalers, eye drops, ointments, patches, oxygen, etc.

❑ NO HOME MEDICATIONS Name of Patient's Pharmacy: _____

ARE YOU TAKING BLOOD THINNERS? ❑ YES ❑ NO **ARE YOU TAKING BLOOD SUGAR / DIABETIC MEDICINE?** ❑ YES ❑ NO

MEDICATION NAME	DOSE	ROUTE	FREQUENCY	PURPOSE	LAST TAKEN	COMMENTS
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑ _____	
					❑ TODAY ❑	

NOTE: Continue list of patient's home medications on page 2, if needed

STAFF SIGNATURE _____ DATE_____ TIME_____

OhioHealth

1MREC

PATIENT IDENTIFICATION LABEL

AMBULATORY MEDICATION RECONCILIATION