Medication List & Reconciliation Form

Please provide a complete and accurate list of all medications, supplements, and over-the-counter products you are currently taking. This information helps ensure your safety and the best possible care.

Patient Information

Please provide your identifying information.

Full Name *

First Name Last Name

Date of Birth *

Phone Number *

Email Address *

Date Completed *

Pharmacy Information

Details of your primary pharmacy.

Primary Pharmacy Name *

Pharmacy Phone Number *

Pharmacy Address (optional)

Current Prescription Medications

List all prescription medications you are currently taking.

List all current prescription medications (include name, dose, frequency, route, and purpose). *

Prescriber(s) for current medications (include provider name and contact if known).

Over-the-Counter Medications & Supplements

Include all non-prescription products you are taking.

Select all types of over-the-counter products or supplements you are currently taking:

- ☐ Vitamins
- ☐ Minerals
- ☐ Herbal Supplements
- ☐ Pain Relievers (e.g., acetaminophen, ibuprofen)
- ☐ Cold/Allergy Medications
- ☐ Digestive Aids (e.g., antacids, laxatives)
- ☐ Other

Please list all over-the-counter products and supplements you are currently taking (include name, dose, frequency, and purpose).

Recently Discontinued Medications

Information about medications you have stopped recently.

Have you recently stopped taking any medications? *

- ◯ Yes
- ◯ No

If yes, please list the discontinued medications, date stopped, and reason for discontinuation.

Medication Allergies & Adverse Reactions

Report any allergies or adverse reactions to medications.

Do you have any medication allergies or have you experienced adverse reactions to medications? *

- ◯ Yes
- ◯ No

If yes, please list the medication(s) and describe the reaction(s).

Do you have any other (non-medication) allergies?

- ◯ Yes

- ◯ No

If yes, please specify your non-medication allergies.

Medication Adherence & Safety Screening

Questions about how you take your medications and any safety concerns.

Do you ever have trouble remembering to take your medications as prescribed? *

- ◯ Yes
- ◯ No

If yes, please describe any challenges with medication adherence.

Have you experienced any side effects or safety concerns with your medications? *

- ◯ Yes
- ◯ No

If yes, please describe any side effects or safety issues.

Duplicate Therapies / Drug Safety Check

Help us identify any duplicate therapies or potential drug safety issues.

Check any of the following that apply to your medication list:

- ☐ Taking two or more medications for the same condition
- ☐ Taking medications from the same class
- ☐ Drug interaction concerns
- ☐ Other

If checked, please provide details about duplicate therapies or safety concerns.

Special Considerations

Let us know about any special considerations or needs.

Check any of the following that apply:

- ☐ Difficulty swallowing pills
- ☐ Need for liquid or chewable forms
- ☐ Religious or dietary restrictions
- ☐ Other

If checked, please provide details about any special considerations.

Review & Confirmation

Please review your information and confirm the following.

I confirm that the information provided is complete and accurate to the best of my knowledge. *

☐ I confirm the above statement

Signature Section

Please provide your signature to complete this form.

Printed Name *

Signature (please sign below) *

Date of Signature *