

**MEDICATION LIST**

Home medications for reconciliation for present office visit.

**Please complete this medication list form.** If you are taking more than 10 medications, continue on the next page. Bring this medication list to your appointment.

**Patient Name:** \_\_\_\_\_, \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

**Date of Birth:** \_\_\_\_\_ **Date List Completed:** \_\_\_\_\_

**Person Completing List:** \_\_\_\_\_, \_\_\_\_\_  
(If other than patient) (Last Name) (First Name) (Middle Initial)

Medication	Dose	Frequency	Reason for Medication	Route (for example- by mouth, eye drops, or by injection)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**Over-the-Counter Medications (Drugs), Vitamins, and Herbal Preparations:**

\_\_\_\_\_

**IF YOU TAKE MORE MEDICATIONS, CONTINUE ON REVERSE SIDE**



# Good Samaritan Hospital Surgery

For Office Use Only

Medication	Dose	Frequency	Reason for Medication	Route (for example- by mouth, eye drops, or by injection)
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				

Form reviewed with patient by: \_\_\_\_\_