MEDICATION LIST

Directions: Please complete this medication list and bring to your first appointment. Use back of form if more space is required. Thank you.

Allergies/Adverse Reactions

Date Allergy started	Name of Agent (Medication, Food, etc.)	Type of Reaction (Describe – e.g., itching, hives, etc.)	Indicate if reaction is mild, moderate or servere.

List all Over the Counter medications and Nutritional Supplements-including tube feedings

	Date	Medication	Route	Strength	Dose	Frequency
1						
2						
3						
4						
5						
6						
7						
8						

List all medications currently prescribed

	Date	Medication	Route	Strength	Dose	Frequency
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

Signature:_____Date_____

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ADDITIONAL MEDICATION RECONCILIATION

DIRECTIONS: Healthcare Provider *to review and reconcile all medications each visit*, update with changes from *Nursing Assessment & Treatment Sheet.* Enter DC for discontinued, rewrite new/change on new line

List all Over the Counter medications: (Includes vitamins/ minerals, herbal/natural products and recreational)

	Date	Medication	Dose	Frequency	Route	Initials
6						
7						
8						
9						
9						
10						
11						

(continue on additional page if necessary)

List all medications that patient reported as prescribed for them:

	Date	Medication	Dose	Frequency	Route	Initials
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						

(continue on additional page if necessary)

List all medications prescribed by Wound Care physician(s):

	Date	Medication	Dose	Frequency	Route	Initials
6						
7						
8						
9						
10						
11						
12						

(continue on additional page if necessary)

_____ _____

(Signature/Initials) Date/Time (Signature/Initials) Date/Time

(Signature/Initials) Date/Time (Signature/Initials) Date/Time

Additional Allergies/Adverse Reactions

Initials	Date	Name of Agent (Medication, Food, etc.)	Type of Reaction (Describe – e.g., itching, hives, etc.)