Pharmacy Medication Reconciliation Form

Patient Name: **Date of Birth:** **Room #:**	**Allergies:**				**Immunization History:**
Community Rx Info: **Prescription Insurance:**	**Social History**				
	Diet/Exercise	**Alcohol**	**Tobacco**	**Recreational**	

Complete Medication History Prior to Admission (write legibly)								**Med Reconciliation**	
Medication Name Strength Route			**Freq**	**PRN?**	**Last Dose (date/time)**	**Adverse Effects**	**Adherence**	**Action**	***Reason for discontinue, hold, modify**
				☐					
				☐					
				☐					
				☐					
				☐					
				☐					
				☐					
				☐					
				☐					

Additional Notes:	Action Key - **C:** Continue **D:** Discontinue* **H:** Hold* **M:** Modify* (*provide reason)
Med History obtained by (sign and print name):	**Date:**