Medication History

A complete medication history will help improve drug therapy, minimize the risk of drug interactions as well as decrease the number of adverse drug events. Please answer all questions as thoroughly as possible. All answer's are confidential as part of your patient medical records. ****Please bring all mediations to the first visit.****

Your Name:_____

Person Completing this Form:_____ Date:_____

Name of Primary Medical Provider:_____

Specialists? Neurologist:_____ Cardiologist:_____

Ophthalmologist:_____ others:_____

Where do you get your prescription medications? Please name below:

Community Pharmacy:_____ HMO (i.e. Kaiser):_____ Mail-order:_____

City:_____ Tel:_____

1. How are the medications given?

A. By me_____ By Caregiver_____
B. Multi-dose Vials (pill vial)_____ Mediset (box, organizer)_____ Not sure_____
C. Swallows_____ Feeding Tube_____
D. Are any of the tablets crushed or capsules opened?
No_____ Yes_____ If yes, please explain_____

2. How many doses of medications were missed in the past week?

No doses were missed_____ 1-2 Doses_____ 3-4 Doses_____ More than 4 doses were missed_____

3. What medications are you currently taking? (Please list **ALL** medicines prescribed by any medical doctor, including dentist, podiatrist, and nurse practitioner)

Name of Medication	Strength of each pill	How often is it taken?	How long has the subject been taking it?	What is it taken for?
1.				
2.				
3.				

(Please use next page to list more medications)

Additional space to list medications the client is currently taking:

Name of Medication	Strength of each pill	How often is it taken?	How long has the subject been taking it?	What is it taken for?
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

4. What other prescription medications, now discontinued , have you taken in the past 15 days?

Name of Discontinued Medication	Reason medication was stopped
1.	
2.	
3.	
4.	

(Please use reverse side to list more medications)

5. What medications are you taking that do not require a prescription? (This includes medications purchased in a Pharmacy, Drug Store, Grocery Store, Mail-Order, etc. Examples: Tylenol, Benadryl, etc.)

Name of Medication	How often is it taken?	What is it taken for?
1.		
2.		
3.		
4.		
5.		

(Please use reverse side to list more medications)

What do you take for pain?_____ How often?_____
Does it relieve the pain? Yes___ No____

What do you take for upset stomach or constipation?_____ How often?_____

6. What Herbal Medicines do you take? (These include all home remedies, herbal teas and herbal pills, amino acids, and nutritional supplements purchased in a health food store)

Name of Herbal Medicine (If available, include Brand Name and Generic Name)	Please list Active Ingredients below (often found on back of bottle or box)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

(Please use reverse side to list more medications)

Where were these herbal medications purchased? Place a check mark by all that apply:

Pharmacy___ Health Food Store___ Herbal Store___ Herbalist___ Mail order___
I grow my own herbs_____ Other (please name):_____

Do you believe any of these medications have improved your condition? Yes___ No___
If Yes, which products and what was their effect:_____
_____

****Please bring these herbal medications and other medications to the first clinic visit. ****

7. What Vitamins and Minerals do you take?

Multi-vitamin:___ Brand:_____ Strength:_____ # of tablets per day:_____

Vitamin C:___ Brand:_____ Strength:_____ # of tablets per day:_____

Vitamin E:___ Brand:_____ Strength:_____ # of tablets per day:_____

Other (Name, brand, strength, # per day):_____

Other (Name, brand, strength, # per day):_____

(Please use reverse side to list other Vitamins and Minerals the subject takes)

8. How often do you drink alcohol?

Never___ Once a Month___ Once a Week___ Once a Day___ More than one drink per day___

When was the last drink?_____ Is alcohol ever used to improve sleep or reduce anxiety? Yes__ No__

When the client drinks alcohol, what does he/she drink?_____

9. Do you smoke cigarette or cigars or chew tobacco?

No, has never smoked_____ Do not smoke anymore, quit smoking on:_____

Yes, he/she smokes: Less than 1 pack per day____ 1 pack per day____ More than 1 pack per day____

How long have you smoked?_____

10. How much of the following beverages do you drink?

Coffee: Does not drink coffee:_____ Drinks 1 cup or less/day_____ Drinks 1-2 cups/day_____
Drinks 3-5 cups/day_____ Drinks more than 5 cups/day_____
Drinks only decaffeinated coffee_____

Tea: Does not drink tea:_____ Drinks 1 cup or less/day_____ Drinks 1-2 cups/day_____
Drinks 3-5 cups/day_____ Drinks more than 5 cups/day_____
What kind of tea does he/she drink?_____

Soft Drinks with Caffeine (for example: Coke, Pepsi, Mountain Dew, Jolt, Dr. Pepper):

Does Not Drink Soft Drinks____ Yes, Drinks Soft Drinks_____ How many 12 oz. cans/day?_____

11. Within the past month, have you used marijuana or other social drugs such as stimulants, hallucinogens, narcotics or sedatives (not prescribed by a physician)?

No_____ Yes_____ If yes, please specify:_____

12. In the past week, have you taken any medications prescribed for someone else?

Check All That Apply:

No_____ Yes_____ If yes, what is (are) the name of the medication(s)?_____

13. Did the client receive a flu shot last year?

No_____ Yes_____

This year? No_____ Yes_____ Not yet, but plan to receive the flu shot_____

14. Hav you ever had a bad reaction to any medication or experienced any drug allergy?

No_____ Yes_____ If yes, please name the medication(s):_____
_____

Reaction type: Rash_____ Shortness of Breath_____ Other (please describe):_____

Did the reaction require treatment? No_____ Yes_____ What was the treatment?_____

When did this reaction occur?_____

Has he/she ever tried the medication again? No_____ Yes_____ If yes, what happened?_____

Does he/she have an allergy to: Penicillin___ Sulfa-containing drugs___ Aspirin___
Local Anesthetic____ Other (describe)_____

15. Are you on a special diet?

No_____ Yes_____ If yes, please describe:_____

Thank you for taking the time to complete this medication history form.

(R.Finley, B.S. Pharm., R.Ph. and Hanah Ha Pharm .D, Department of Clinical Pharmacy, School of Pharmacy, University of California, San Francisco, CA. 2002.,Reproduction by permission)