Medication History Record

Name: _____

Reference Record #_____ Tel: (home):_____ (Mobile) _____

Date of Birth: _____ Gender: □ Male □ Female

Insurance Details: _____

Current Diagnosis

Any Allergies

Family medical history of allergies and any notable conditions

Occupation: _____ Location: _____

Hobbies:

_____

Travel: □ Domestic □ International

% of travel involved _____

Immunizations (last 5 yrs) □ Td_____

□ Flu _____ □ Pneumonia _____

Diet: □ Balanced □ Frequency _____

Caffeine: □ No □ Yes amount_____ source _____

Tobacco: □ No □ Yes amount _____ Years ____ Quit on _____

Alcohol: □ No □ Daily □ Weekly □ Monthly amount _____

Any recreational drugs or steroids used

Source of Medications:
□ local pharmacy □ mail order □ Internet
□ samples □ foreign (Canada / Mexico)
□ other (provide details below)

Any Cost Issues*: □ No □ Yes

Any Accessibility Issues*: □ No □ Yes

Medication storage location*

Are the containers labeled* □ Yes □ No

Are they accessible to children* □ Yes □ No

Are expired medications discarded*
□ Yes □ No

*Include any notes additional info as required

Current Prescription Medications Used

Name of the medication	Dosage	Frequency	Taken last on?	Taken regularly?	Allergic reactions or Side Effects	Prescribed for
			/ /			
			/ /			
			/ /			
			/ /			
			/ /			
			/ /			
			/ /			

Prescription Medications not being used currently, but used any time in the past 3 months

Name of the medication	Dosage	Frequency	Taken last on?	Side Effects	Reason for Stopping
			/ /		
			/ /		
			/ /		

Any Over The Counter medications used					
Symptom	**Medication & Dosage**	**Frequency**	**Started taking on**	**Last taken on**	**Side Effects**
Pain			/ /	/ /	
Diarrhea or constipation			/ /	/ /	
Nausea			/ /	/ /	
Heartburn			/ /	/ /	
Cough			/ /	/ /	
Congestion / Sinus			/ /	/ /	
Allergies			/ /	/ /	
Sleeping Aid			/ /	/ /	
Skin problems			/ /	/ /	
Weight Loss			/ /	/ /	
Anxiety			/ /	/ /	
Depression			/ /	/ /	
Menstrual issues			/ /	/ /	
Menopause			/ /	/ /	
Vitamins / Herbs			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

Notes / Comments: _____

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