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 anytime in the past 3 months

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

Any OTC 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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