Adventist Midwest Health

☐ Adventist Bolingbrook ☐ Adventist GlenOaks ☐ Adventist Hinsdale ☐ Adventist La Grange Memorial

| Allergies: Drug/Food | Reaction/Side Effects |
|---|---|
| ☐ No Known Drug Allergy | |
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| | |

Latex allergy or sensitivity? ☐ Yes ☐ No ☐ Unsure

Iodine allergy? ☐ Yes ☐ No Allergy to dyes? ☐ Yes ☐ No

If yes, describe type of reaction:

Last Menstrual Cycle: _____ ☐ N/A

Pregnant ☐ Yes ☐ No ☐ N/A Lactating ☐ Yes ☐ No ☐ N/A

☐ **On No Medication at Home** Height: _____ ☐ inches ☐ cm Weight: _____ Actual ☐ lbs ☐ kg

☐ Unable to Obtain Medication History **Reasons** _____

Information Source: ☐ Patient ☐ Family ☐ Patient's Drug List/Wallet Card ☐ Medications brought From Home ☐ Other

**Home Medications on Admission**
(Prescriptions, OTC's, Vitamins, Patches, Inhalers, Eye Drops, Herbals & Supplements)

| Drug Name | Dose | Route | Frequency | Indication | Last Taken Date/Time | ☐ Not applicable Told to Take / Stop Date |
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**NEW MEDICATIONS and/or CHANGES TO PREVIOUS MEDICATIONS**

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|---|---|---|---|---|
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| | | | | |

Person Reviewing Medication History: _____ Date/Time _____
Signature Title

_____ Date/Time _____
Signature Title

_____ Date/Time _____
Signature Title

**DO NOT REMOVE THIS FORM FROM THE MEDICAL RECORD**

You gave to us the information contained in this form. Your doctor requests that if you have any questions about a particular medication or this information does not match the medications you have at home, please call the doctor who prescribed the medication(s) for clarification.

Patient Signature: _____

**Outpatient Medication Reconciliation**



White - Medical Record
Canary - Pharmacy
Pink - Physician

901394 9/07

PHYORDER

Place Label Here