PATIENT MEDICATION INVENTORY

HOME MEDICATION LIST

DATE_____________

(INCLUDES HERBALS, OVER THE COUNTER MEDS AND HOME REMEDIES)

Name of Med	Purpose	Dose	Schedule	Started	Stopped	Side Effects

RX THIS ADMISSION

Pharmacy Used	Name of Med	Purpose	Dose	Schedule	Possible Side Effects

Allergies *(to include food)*:____

Date Reviewed: _______20___ by: ___________________

Reviewed with: ☐ patient ☐ care person

Date Reviewed:_______20____by:________________

Reviewed with: ☐ patient ☐ care person

Date Reviewed: _______20___ by: ___________________

Reviewed with: ☐ patient ☐ care person

Date Reviewed:_______20____by:________________

Reviewed with: ☐ patient ☐ care person

Copied to:

☐ Patient

☐ Attending physician

☐ Referring physician

☐ Next in line of care physician

☐ Other: _______________________

PATIENT LABEL