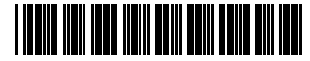


Patient Self Report Home Medication List



Information Source: Patient/family Pharmacy: _____ Previous record
 Patient Med List Primary Care Physician List Other: _____

Allergies (medication/food/latex):

Patient is taking no medications/supplements Unable to obtain medication list due to: _____

Clearly list all Prescription and over the counter (OTC) medications/supplements/herbal preparations.

Do Not Use Medical Abbreviations

Date/Time	Medication	Dose	Frequency	Last Dose Taken (if applicable)	Special Instructions

MEDICATIONS CHANGED ON THIS VISIT BY THE PHYSICIAN:

Date/Time	Medication	Dose	Frequency	Last Dose Taken (if applicable)	Special Instructions

Post Treatment Medications (if applicable): Page ____ of ____
 No change to home medications
 Additional prescriptions provided. See above.
 Changes to home medications. See above.

Initiated (signature): _____ Date/Time: _____
 Completed (signature): _____ Date/Time: _____

Please bring this list with you to all clinic/doctor visits

Date	Change	No change	RN/L PN



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PLACE
 PATIENT LABEL
 HERE