UF UNIVERSITY of FLORIDA

Medication Reconciliation Form

Patient Name: _____ Age: _____

Physician(s): _____ _____ _____

Pharmacy Name(s): _____ Phone number: _____

Do you have any known drug allergies/sensitivities? YES NO

Please list (with date) and define reaction: _____

Collect a medication history of all prescriptions, OTC products, herbals, and vitamins/supplements.

Medication Name and Strength	How do you take it? (Route/Timing)	How often do you take it?	Why do you take this medication?	Comments/Notes

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