



1

Patient Medication History Form

Patient:

Primary Physician:

Date:

Allergies (product/reaction)

No Known Drug Allergies

Comments:

Prescription Medication				Patient Knowledge				Usage			Adverse Effects	Comments	
A	B	C	D	E	F	G	H	I	J	K	L	M	
Name	Dose	Route	Frequency	Name	Reason for Use	Dosage/Frequency	Special Instructions	Labeling and Packaging Appropriate	Storage Appropriate	Expiry Date	Patient Adherence		
1.												1.	
2.												2.	
3.												3.	
4.												4.	
5.												5.	
6.												6.	
7.												7.	
8.												8.	
9.												9.	
10.												10.	

• Complete columns A-D with the aid of a pharmacist • Place a “-” to acknowledge discussing columns E-L
 • List any adverse effects due to medications: e.g. effect, frequency, severity in column M



Patient Medication History Form (continued)

OTC				Background			Usage			Comments	Adverse Effects
A	B	C	D	E	F	G	H	I	J	K	
Name	Dose	Route	Frequency	Reason for Use	Evidence of Benefit	MD Awareness	Storage Appropriate	Expiry Date	Patient Adherence		
1.										1.	
2.										2.	
3.										3.	
4.										4.	
5.										5.	
Complimentary Medications				Background			Usage			Comments	Adverse Effects
1.										1.	
2.										2.	
3.										3.	
4.										4.	
5.										5.	
6.										6.	

• Complete columns A-F with the aid of a pharmacist • Place a “.” to acknowledge discussing columns G-J
 • List any adverse effects due to medications: e.g. effect, frequency, severity in column K