**SIBLEY MEMORIAL HOSPITAL**
**PATIENT MEDICATION LIST**

**PATIENT OR FAMILY:** Please list all medications you are currently taking. Include all prescription medications, over the counter medications, supplements, eye drops, and or herbals.

Person Completing Form (print name): ___________________________ Relationship to Patient: ___________________________

- [ ] No Medications
- [ ] Unable to obtain history, reason:
- [ ] No Known Allergies
- [ ] List Allergies to drugs and reaction, food and reaction, and if allergic to latex: ___________________________

Vaccine/other History: Check (✓) all vaccines received and list date if known.
- [ ] Vaccine history not known
- [ ] Pneumonia vaccine/Date: ___________________________
- [ ] Influenza vaccine/Date: ___________________________
- [ ] Rhogam/Date: ___________________________

**MEDICATION NAME:** *(WRITE LEGIBLY)*

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>Dose (mg, mcg, other)</th>
<th>Route (oral, other)</th>
<th>Frequency (how often)</th>
<th>Last Dose (date/time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attach to form:</td>
<td>Patient list</td>
<td>Facility list</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOR HOSPITAL USE ONLY**

Information Source (circle): Patient Family MD List Container Pharmacy EMS Other:

For any updates, complete and attach additional PATIENT MEDICATION LIST

List Reviewed by (print name): ___________________________ Date: ___________ Time: ___________

**MEDICATIONS AT DISCHARGE:** *(OUTPATIENT ONLY)*

- [ ] Copy of medication prescriptions placed in medical record, originals to patient

New medication at discharge, change in prior medication prescribed, or special instructions:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Instructions, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Patient/Family/Power of Attorney**

Signature: ___________________________ Date/Time: ___________________________

**Nursing**

Signature: ___________________________ Date/Time: ___________________________

**Physician/LIP/Pharmacist**

Signature/Authentication: ___________________________ Date: ___________ Time: ___________