

ADMISSION MEDICATION HISTORY FORM

*Dear Patient,
Please list all the medications that you are currently taking at home. Please include prescription medications, non-prescription medications (over-the-counter), vitamins, herbals and vaccination information if available.*

Allergies: _____ Height: _____ Weight: _____

Prescription Medications (Please write clearly using ink.)				For UCLA use only		
<input type="checkbox"/> Not taking any medications at home.				Healthcare Provider Review		
Medication	Dose	Directions for Use (How often are you taking it? For example: once daily, twice daily)	Time/ Date of last dose	Continued on admit	Reconcil- iation Needed/ Done	Drug supply at home
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Over the Counter Medications/Vitamins/Herbal Agents/Vaccines						
1.						
2.						
3.						
4.						

Immunization Status:	Influenza: _____	Last Received: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> never	Pediatrics: Immunizations Up to Date <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Pneumococcal: _____	Last Received: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> never	
	Tetanus: _____	Last Received: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> never	

Patient Signature: _____ Date: _____ Time: _____

Below is for UCLA use only:
Notes: _____

Pharmacist (Print) Name: _____ Date: _____ Time: _____
Pharmacist Signature: _____ Pager: _____

Note: PTU RN – please fax to OR pharmacy x48118

**While patient is in-house, PLACE form at the front of the PROGRESS NOTE SECTION
PART OF PERMANENT MEDICAL RECORD**