

UNIVERSAL MEDICATION FORM

Patient Name: _____ Date of Birth: _____
 Height: _____ ft _____ in Weight: _____ lbs

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)	
PNEUMONIA VACCINE	FLU VACCINE(S)
Allergic To /Describe Reaction:	Allergic To /Describe Reaction:

LIST ALL MEDICATIONS YOU HAVE TAKEN DURING THE LAST 30 DAYS: Prescription and over-the counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION	DOSE (mg, mcg, units, etc.)	DIRECTIONS: How often do you take this medication? (Daily, as needed, 3 times a day, etc.)	REASON FOR TAKING THIS MEDICATION	TO BE COMPLETED BY MD		
				CONTINUE TAKING MEDICATION	DISCONTINUE TAKING MEDICATION	STOP DATE

HOW DOES THIS FORM HELP YOU?

1. This form provides your doctor(s) and others with a **current list of ALL of your medications**. Doctors need to know the prescription, herbals, vitamins, and over-the-counter medicines you take to make medical decisions and provide optimal care.
2. This helps you, because physicians are able to identify potential medication interactions and develop an appropriate treatment plan during your stay.

BAYLOR SCOTT & WHITE MEDICAL CENTER – FRISCO

Medication Reconciliation



MEDREC

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