Bayhealth Medical Center

Maternal-Fetal Medicine **Women's Care Associates**
Family Practice Associates-Georgetown
Medical Associates – Milford
Medical Associates - Milton

Patient Label

Outpatient Medication Reconciliation - Physician

Date:	Person Taking History:	Pregnant: Y N (circle one)
Birth date:	Age: Weight: (/kg) Height:	Breastfeeding: Y N (circle one)

Name of Pharmacy: _____ Telephone: _____

Allergy Information: *please circle as indicated*

NKDA Penicillin Latex Allergy Iodine/Shellfish Contrast Media Adhesive Tape Environmental

Allergies: Medications / Food	Reaction Adverse Effects / Intolerance

Current Medications: *Please include OTC's, Herbals, Patches, Vitamins/Nutritionals, Inhalers, Eye Drops*

Information obtained from: *(please circle)* Patient Family Wallet Card Meds from home Other _____

Date Started	Drug Name/Strength	Route	Dose	How Often	Reason	Last Dose	Continue at Discharge?	Provider's Initials

New Medications: *(please circle)* Prescription E-Prescribe Samples Given

New Medication	Dose	Route	How Often	Reason	Sample	Lot Number/ Expiration Date

Reviewed with patient, no changes noted: ***please date and initial below***

Provider's Signature: _____ Date: _____ Time: _____