

Medication History Collection Form

Patient Name

Date of Birth

Medical Record Number (MRN)

Allergies

Usual Pharmacy

Current Medications

Medication Name	Dosage	Frequency	Route	Last Dose Taken	Indication
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Recent Changes/Stopped Medications

Non-Prescription Drugs (herbal, vitamins, OTC, etc.)

Source of Information

Collected By

Date/Time Collected