OneCore Health

1. ALLERGIES AND REACTION: ☐ No known allergies or _____

_____

FOOD ALLERGIES: ☐ No known allergies or _____

_____

2. MEDICATIONS: (Include topicals, ointments, liquids, parenterals, oxygen, inhalers, drops, over-the-counter medications, herbals & vitamins)

PROVIDER ONLY Check meds to be continued while in the Hospital ☐ N/A-Outpatient	**MEDICATION NAME**	**DOSAGE** Include any variables. For example: 15mg 1-2 tabs.	**ROUTE** By mouth, injection, topical, inhalation, IV, etc.	**FREQUENCY** How often?	**INDICATION** What does the patient take the medication for?	**PRE-OP ONLY** Date/time of last dose (to be done on date of surgery).	**PROVIDER ONLY** On Discharge Check Meds to be Continued at Home
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N
☐Y ☐N							☐Y ☐N

3. SOURCE OF INFORMATION:
☐ No home medications ☐ Patient
☐ Medication list ☐ Patient's family ☐ Medication bottles ☐ Old chart
☐ Nursing home ☐ Doctor's office ☐ Pharmacy ☐ Other _____

4. MEDICATION HISTORY INITIATED BY: _____ Date/Time: _____

5. PHYSICIAN/PA/ARNP SIGNATURE: _____ Date/Time: _____

6. MEDICATION HISTORY UPDATED BY: _____ Date/Time: _____

MEDICATION HISTORY UPDATED BY: _____ Date/Time: _____

7. ADDITIONAL HOME MEDICATIONS FOR PATIENT DISCHARGE. *To be completed by hospital staff at discharge.*

MEDICATION	**DOSE/ROUTE/FREQUENCY/COMMENTS**	**NEXT DOSE?**	**RX GIVEN?**
			☐Y ☐N
			☐Y ☐N
			☐Y ☐N
			☐Y ☐N
			☐Y ☐N

8. ☐ **COPY GIVEN TO PATIENT OR SIGNIFICANT OTHER BY:** Date/Time:

ONECORE HEALTH ORTHOPEDIC HOSPITAL
MEDICATION HISTORY/RECONCILIATION FORM

Place patient label here. If not available, complete:
Patient name:
DOB:
DOS: