

and



Admission Medication History Form

Patient Name: _____

UCLA Medical Record Number: _____

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: _____ Ht: _____ Weight: _____

Prescription Medications			For UCLA use only Healthcare Provider Review			
<input type="checkbox"/> Not taking any medications at home.						
Medication	Dose	Directions for Use (how often are you taking it?)	Continued on admit	Recon- cilia- tion Needed/ Done	Drug supply available at look	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Over the Counter Medications/Vitamins/Herbal Agents/Vaccines						
1.						
2.						
3.						
4.						
Immunization Status:	Influenza: Pneumococcal: Tetanus:	Last Received: _____ Last Received: _____ Last Received: _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown	<input type="checkbox"/> never <input type="checkbox"/> never <input type="checkbox"/> never		

Patient Signature: _____

Date: _____