

**MEDICATION RECONCILIATION**

**Taylor Health and Wellness Center**

(Patient Name Label)

Name: \_\_\_\_\_  
Date of Birth : \_\_\_\_\_  
Todays Date: \_\_\_\_\_

**Prescription Medications:** (Include Tablets, Capsules, inhalers, injections, creams, ointments, suppositories, eye drops, etc)

MEDICATION Brand / generic	STRENGTH (mg/tab)	Amt taken per dose	When Taken	Reason Taken (patient description)	Dr /NP Comments (changes/explanations/etc)

**Over the counter Medications** (include supplements, herbs, OTC products in last 30 days)


This is an actual list of all the medications I am taking \_\_\_\_\_ date \_\_\_\_\_  
List reviewed by \_\_\_\_\_ date \_\_\_\_\_

**Medication changes made with todays appointment (or additions/changes by other Physicians)**


Physician / Nurse Practitioner Reviewer \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_