The Cosmetic & Skin Surgery Center

Medication Reconciliation Record

DOB _____ Patient Name _____

Please list ALL known prescriptions, over- the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements.

Name (Reported by Patient)	**Dosage**	**Frequency**	**Route** (Oral, Sub-Q)

Are you ALLERGIC to any drugs or materials? ❒ YES ❒ NO If yes, list:

Allergy or Sensitivity (Reported by patient)	**Reaction**

LATEX ALLERGY ❒ YES ❒ NO **Patient Initials** _____ **Staff Initials** _____

_____ _____ _____

(Physicians Initials) (Patient Signature) (Date)

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Medication Reconciliation Record Log

My signature confirms that I have reviewed the original list of prescriptions/medications. I have marked and dated all changes, and to the best of my knowledge, is up-to-date and inclusive.

Date	Patient/Guardian Signature	Physicians Initials