

# SAN DIEGO ENDOSCOPY CENTER

Patient Name

## Patient Home Medication Reconciled List

*\* Home Medication List is as provided by the Patient*

(Including prescriptions, over the counter, herbals, vitamins and birth control pills or patch)

ALLERGIES:

REACTIONS:

Medication Name and Dose	Reason for Taking	Last taken (date/time)	Notes	Resume Taking (upon discharge)
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>
				YES <input type="checkbox"/> NO <input type="checkbox"/>

\_\_\_ Takes no medicines at home (including supplements, over the counter or herbal)

\_\_\_ Unable to obtain medication history                      comments: \_\_\_\_\_

\_\_\_ New prescription given to patient (see copy)

Signature Review of Medications and Allergies across the patient care continuum.

Pre-OP Nurse: \_\_\_\_\_

Physician: \_\_\_\_\_

Proc. Nurse: \_\_\_\_\_