Urgent Care Center Home Medication/Herbals/Vitamins List Page _____ of _____

Please answer the following questions:

1. Are you allergic to any medications/food? ❑ Yes (please list below with reaction) ❑ No

_____

_____

2. Have you fallen in the last 30 days? ❑ Yes ❑ No

(No pain Moderate Severe)

3. Are you having any pain today? ❑ Yes (if yes, please circle the level) 0 1 2 3 4 5 6 7 8 9 10 ❑ No

Please list your medications/herbs/vitamins below or indicate you have a list for the staff to photocopy, and give to the receptionist. ❑ Provided for the staff to photocopy.

Medication/Herbal/ Vitamin Name "Please Print"	*Dosage/ Strength*	*Route – How do you take?* *Example: By Mouth*	*Frequency – How often do you take?* *Example: Twice a day*	*Last time you took medication?*

Person completing the list: _____ Date: _____

DO NOT WRITE BELOW THIS LINE FOR STAFF USE ONLY

Discharge Medications:

Medication Name	Dosage/Strength	Route	Frequency/Comments

#0014785 Gate Rev 2/10

Chart – Original Copy – Patient Copy – Next Provider

URGENT CARE CENTER HOME MEDICATION/HERBAL/VITAMINS LIST

Brazosport REGIONAL HEALTH SYSTEM

100 Medical Drive Lake Jackson, TX 77566

Patient ID