Medical Reconciliation Form

Have you taken any of the following medications in the past three weeks? yes no

Please check the box(s) below:

☐ Tranquilizers	☐ Anti-Depressants	☐ Sulfa	☐ Diuretics (Water Pills)	☐ Diet Pills	☐ Aspirin	☐ Kava Kava
☐ Birth Control Pills	☐ Hormones	☐ Advil	☐ Aleve	☐ Motrin	☐ Ibuprofen	☐ Vitamin E
☐ Vitamin Supplements	☐ Gingseng	☐ Garlic	☐ Ginko Biloba	☐ Oral Diabetic Pills	☐ Cholesterol	
☐ Ma Huang	☐ Ephedrine	☐ St. John's Wort	☐ Golden Seal	☐ Multi-Herb Supplements		

Please specify below the names of medications, the dosage and frequency including additional medications which are not listed:

Medications	Dosage	Frequency	Reason for taking each medication:

Please list below ANY allergies you may have:

Medication: ______________________ **Reaction:** ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Patient Signature: ______________________ Date: ______________________