UW Medicine
NEIGHBORHOOD
CLINICS

Medication History Form

Patient Name: _____ Date: _____

Allergies

Name of Substance (drug or food)	**Type of Reaction**
☐ Check if none	

Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing, etc.? ☐ Yes ☐ No

For female patients ONLY: Are you currently pregnant? ☐ Yes ☐ No

Are you considering becoming pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Current Medications

Prescription Drugs (such as Atenolol, eye drops, ointments)	**Strength** (5 mg, etc)	**Directions** (such as 1 tablet twice a day) *Check box if taken only as needed.*		**Name of the provider who prescribed the medication**
☐ Check if none				
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

Over-the-Counter Medications (such as ibuprofen)	**Strength**	**Directions** (such as "take as needed for pain")

Herbs, Vitamins, Minerals, Etc. (such as St. John's Wort)	**Strength**	**Directions** (such as one tablet per day)