

PAIN PROCEDURE MEDICATION HISTORY/RECONCILIATION

Patient Name _____ Date of Birth _____

Height _____ ft _____ in Weight _____ lbs

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

LIST ALL CURRENT MEDICATIONS: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION	DOSE (mg, mcg, units, etc.)	DIRECTIONS: How often do you take this medication? (Daily, as needed, 3 times a day, etc.)	REASON FOR TAKING THIS MEDICATION	LAST DOSE DATE / TIME	
				1ST VISIT	2ND VISIT

PATIENT SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

DATE	NAME OF MEDICATION ADDED OR STOPPED	DOSE	DIRECTIONS	REASON

DISCHARGE PHYSICIAN SIGNATURE: _____

DATE: _____ TIME: _____

PATIENT SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

DATE	NAME OF MEDICATION ADDED OR STOPPED	DOSE	DIRECTIONS	REASON

DISCHARGE PHYSICIAN SIGNATURE: _____

DATE: _____ TIME: _____

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*Only necessary if adding to or holding medication in medication history.

NAME OF MEDICATION	DOSE (mg, mcg, units, etc.)	DIRECTIONS: How often do you take this medication? (Daily, as needed, 3 times a day, etc.)	REASON FOR TAKING THIS MEDICATION	LAST DOSE DATE / TIME	
				1ST VISIT	2ND VISIT

PATIENT SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

DATE	NAME OF MEDICATION ADDED OR STOPPED	DOSE	DIRECTIONS	REASON

DISCHARGE PHYSICIAN SIGNATURE: _____

DATE: _____ TIME: _____

PATIENT SIGNATURE: _____ DATE: _____ TIME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____

DATE	NAME OF MEDICATION ADDED OR STOPPED	DOSE	DIRECTIONS	REASON

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