BARNES-JEWISH Hospital
BJC HealthCare

OUTPATIENT HOME MEDICATION RECORD

Washington University in St. Louis
SCHOOL OF MEDICINE

ADDRESSOGRAPH

Please check (✓) the appropriate box (☐) and fill in the blank(s) as needed.

Please list any medications you are currently taking. Please include: medicines prescribed by your doctor, over-the-counter medicines (allergy relief, antacids, cold/cough medicines, laxatives, aspirin or other pain, headache or fever medicines, diet pills, etc.), herbal products (e.g., Gingko Biloba, St. John's Wort, Ginseng, Green Tea, etc.), vitamins and nutritional supplements (multi-vitamins, Glucerna, Boost, etc.)

Medication	Dose	How Often	Route
☐ No Home Medications			Medicine taken by: (mouth, injection, other [please specify])

Home Medications List completed by: ☐ Patient ☐ Family Other:_____

Signature of person completing the form: _____

If you have more than one test scheduled for the day, please ask the receptionist to make a copy of this form to take with you.

Staff Use Only

☐ Unable to obtain list of home medication at this time

Registration Number	Location	Staff reviewing information obtained	
		Signature:	Date/Time:
		Signature:	Date/Time:
		Signature:	Date/Time:

DO NOT WRITE BELOW THIS LINE

ORIGINAL - MEDICAL RECORDS
COPY - PATIENT