ORAL & Maxillofacial Surgery
OF CENTRAL NEW JERSEY

MEDICATION RECONCILIATION FORM:

Date: ____________________ **Patient's First Name:**______________________**M.I.:**_____ **Last Name:** ______________________
Acct# ____

Dear Patient, Please list all of your medication that you are currently taking. This includes all over the counter, vitamins, herbal, recreational and alternative medication. Pharmacy Name: _________________________ phone #: _________________________

• Are you currently taking birth control? □ Yes □ No
• Pregnant □ Yes □ No Due Date: _______________________ • Breastfeeding: □ Yes □ No □N/A
• Allergies: ____

	Today's DATE	MEDICATION	DOSE mg	IV	FREQUENCY (indicate times per day or week)	Time of last dose	STATUS AT VISIT **(For office use only)**	
							Resume/Stop	**Date**
1					1x 2x 3x 4x / day / week			
2					1x 2x 3x 4x / day / week			
3					1x 2x 3x 4x / day / week			
4					1x 2x 3x 4x / day / week			
5					1x 2x 3x 4x / day / week			
6					1x 2x 3x 4x / day / week			
7					1x 2x 3x 4x / day / week			
8					1x 2x 3x 4x / day / week			
9					1x 2x 3x 4x / day / week			
10					1x 2x 3x 4x / day / week			
11					1x 2x 3x 4x / day / week			
12					1x 2x 3x 4x / day / week			
13					1x 2x 3x 4x / day / week			
14					1x 2x 3x 4x / day / week			
15					1x 2x 3x 4x / day / week			

Date Updated: ___ / ___ / ___ Initials: _______ Date Updated: ___ / ___ / ___ Initials: _______ Date Updated: ___ / ___ / ___ Initials: _______

Date Updated: ___ / ___ / ___ Initials: _______ Date Updated: ___ / ___ / ___ Initials: _______ Date Updated: ___ / ___ / ___ Initials: _______

New Medications to be added at this visit (will be completed by doctor's office):

	Date	Medication	Dose mg/cc's	Frequency: How many times daily	As needed For pain	Call if any reaction	Stop if any bleeding
1				1x 2x 3x 4x / day			
2				1x 2x 3x 4x / day			
3				1x 2x 3x 4x / day			
4				1x 2x 3x 4x / day			
5				1x 2x 3x 4x / day			