Health Tracking-Medication History Form

Section 1 - General Information

Program Name:*_____

Individual Name:*_____

Reported By:*_____

Entry Date & Time:_____

Time zone:_____

Date:*_____

Notification Level: ▫Low ▫ Medium ▫High

Section 2 - Pharmacy/Prescriber Information

Prescriber:_____

Section 3 - Medication History Information

General Drug Information

Medication Name:*_____

Drug Code:_____

Strength:_____

Medication Type: ▫Scheduled(Medication) ▫PRN(Medication) ▫Scheduled(Treatment) ▫PRN (Treatment)

Drug Coding System: ▫NDC ▫ UPC ▫HRI

Strength Unit:_____

Dose Form:_____

(Tablet, Liquid, Inhalant, Eye drops, Suppository, Capsules, Creams, Drops, Lotion, Ointments, Pad/Patch, Powder, Syrup, Neb, Paste, Tincture, Solution, Elixir, Other)

Note: Allergy Interaction will take place only for Looked Up data.

Compound Drug Components

Name	Code	Coding System	Strength	Give Amount/ Quantity	Measurement Unit	Type Additive/Base	Action

Administration Details

Give Amount/ Quantity	Measure-ment Unit	Frequency	Begin Date & Time	End Date & Time	Days in Interval	Schedule Time(s)	Schedule Interval	Instruction	Action

Route: ▫Oral(mouth) ▫Topical ▫Aural(ear) ▫G-Tube ▫Intra-muscular ▫Intra-venous ▫J-Tube ▫Nasal(nose) ▫Optic(eye) ▫ Rectal ▫Sub-Cutaneous ▫Sub-Lingual ▫Inhaled ▫ Other

Administration Method:_____

Administration Device:_____

Route Instruction:_____

_____

Note: A "Home Medication" is any prescription or over the counter medication that is owned by the individual patient and brought into a facility such as a respite center, nursing home, hospital, etc, that were not ordered for that person by an attending physician or other prescriber on duty at that facility.

Home Medication: ▫Yes ▫ No

▫ Prescription ▫Over the Counter

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Medication Category: ▫General Medication ▫Neurologic ▫Psychiatric Medication Subcategory: _____
Indication/ Purpose:_____
_____
Side Effects:_____
_____
Instruction/ Comments:_____
_____

Link Diagnosis

Description	ICD-10	ICD-9/DSM-4/Other	DSM-5	Status

Attachments: ▫Yes ▫No

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)