Mid Maryland ENT Specialists, P.A.

Medication Reconciliation Record

Patient Name:___________________________________ **DOB:**_________________________

Please list All known prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary supplements.

Name	**Dosage**	**Frequency** (Daily, 2xday, etc)	**Route** (Oral, Sub-Q)

Are you **Allergic** to any drugs or have a **Latex** allergy? If **YES** please list below. ☐ NO/NONE

Allergy or Sensitivity	**Reaction**

__________________________________ _________________ ____________________

Patient or Parent Signature Date Staff Initials