Medication history sheet

Patient details **Name**: **Address**: **Age:** **NHS number**:	**Hospital/ Ward:** Ocean Infirmary **Date of admission:** Today's Date **Tick if NO known drug allergies:** ☐ **Drug allergies/ Intolerances:**

Tick if the patient is on NO regular medications: ☐

Source of drug history (minimum 2 to be used) - please TICK

Patient / Relative ☐   GP practice/ GP patient summary ☐

Repeat prescription list ☐   Emergency care summary ☐

Community pharmacy ☐   GP referral letter ☐

Other: _

Medication			Discrepancies
Name	Dose	Frequency	Outline any discrepancies/ issues

osce toolbox