Patient Name_____ **Date**_____
Birth Date_____

Medication Reconciliation

Please provide a comprehensive list of medications. Include all prescription medications, herbals, vitamins, nutritional supplements, over the counter drugs, vaccines, diagnostic and contrast agents, radioactive medications, parenteral nutrition, blood derivatives, and intravenous solutions.

Medication Name	Dosage TID, BID, UID	Strength	Potency	mg	How taken: Tablet	Capsule	Sup-pos-itory	syringe	other

Vitamin Name	Dosage	How Taken

Medication Allergy List:	When discovered	Type of Reaction	

I give my consent to allow Wiley Chiropractic Group to access my medication history _____yes _____no.

Demographics

Race (Please check only one): ___ American Indian or Alaska Native ___Asian ___African American/Black ___Declined to specify ___Native Hawaiian or Other Pacific Islander ___White

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined to specify

Preferred Language:_____

Patient Name_____ **Date**_____

Smoking Status

Includes cigar or pipe smoke

____Current Some Day Smoker

____Former Smoker

____Never Smoker (if less than 100 cigarettes in a lifetime or none at all)

____Smoker; Current status unknown

____Unknown if ever smoked

____Heavy tobacco smoker- more than 10 cigarettes/day

____Light tobacco smoker less than 10 cigarettes/day

FOR OFFICE USE:

Height_____ Weight_____ BP_____ Pulse Rate_____

Education_____