Children's Hospital Boston

Children's Hospital Boston - Medication History

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Today's Date: _____ **Name (Last, First)** _____ **Date of Birth** _____

Does your child/do you have any food or medication allergies?

If **no** - please check here ☐
If **yes** - Please list

_____

_____

Is your child/ are you currently taking any medication?

If **no** - please check here ☐
If **yes** - please complete chart below

Please write all current prescription medications, herbal products, dietary supplements and over the counter medications your child takes/ you take. Remember to include patches, ointments, creams, ear drops, eye drops or implanted pumps.

Drug Name and description/strength Example: (Over-the-counter Multi Vitamin) (Drug A, liquid, 100/mg/mL)	How much do you give or take? Example: (300 mg)	How often do you give or take? What time(s) of day? Example: (two times a day (8am, 8pm))	How is this drug taken? Example: (by mouth)	Why is your child or yourself taking this medication? Example: (Ear Infection)	When was the last dose given or taken? Example: (Today at 8am)

Is your child less than 14 days old and/or breast fed?

If **no** - please check here ☐
If **yes** - please list any medications the mother is taking

_____

_____

OFFICE USE ONLY

Today's Date _____

CLINICAL STAFF WILL WRITE NEW MEDICATIONS GIVEN TO YOU TODAY BELOW

Drug Name and description/strength	How much to give	How often do you give	How is drug taken	Why you need to take this

Pt. Weight _____ kg

Home pharmacy: _____
Location: _____
Phone (if known): _____

_____ _____
Prescriber Signature Date Time

_____ _____
RN Signature Date Time

I have reviewed this informaion in its entirety with the patient/family and confirmed the information to the best of their knowledge is accurate. ☐