GBMC HEALTHCARE

6701 North Charles Street
Baltimore, Maryland 21204

Patient Medication History

Name: _____ Primary Care Physician:_____
Admitting Physician: _____
Height: _____ Weight: _____

Expected date of admission: _____
Reason for admission: _____
Chronic Conditions: _____
All Allergies and the reaction experienced:

1- _____
2- _____
3- _____

Please fill all medications you are currently taking and review with your Physician, Surgeon, Practitioner, or Pharmacist for accuracy prior to admission.

Name of Medication	Dose	Frequency	Used for	Date of last dose	Resume after discharge

(722-817)10/05