	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Kod Dokumen: HSAAS/FAR/BR204**
	MEDICATION HISTORY ASSESSMENT FORM (CP1)

FORM TO BE FILLED BY THE PHARMACIST UPON PATIENT ADMISSION

Full Name : _____

Gender : **M / F** **Age:** _____

MRN/ IC : _____

Address : _____

_____

Phone No : _____

Admission Date/ Time : _____

Ward/ Bed : _____

PMHX : _____

Last Discharge/ Review Data : _____

REASON FOR ADMISSION

ALLERGY & ADVERSE DRUG REACTION

Patient's own drugs checked?

☐ **YES** ☐ **NO**

Source of Medication List:

MEDICATION (Specify strength)	DOSE	FREQUENCY	BALANCE FROM PREVIOUS SUPPLY	C- CONTINUE DC- DISCONTINUE	COMMENTS

NON-PRESCRIPTION MEDICATION (Includes Herbal/ Vitamin/ Other Supplements)	REASON FOR TAKING	BALANCE/ COMMENTS

PHARMACIST NOTES

Pharmacist's Sign & Stamp: _____ **Time/ Date:** _____