Mount Sinai Fertility
Sinai Health System

PERSONAL MEDICATION LIST AND RECONCILIATION FORM

Name: _____

DOB: (DD-MMM-YY): _____

Please tell us about any medications (prescription and non-prescription), vitamins, and supplements you currently take.
Bring your completed form to your first visit at Mount Sinai Fertility. Both partners (if applicable) should each complete a separate form.
Please inform your doctor of any changes to your medications which arise while you are a patient at MSF so your doctor can update this form.
Medications related to your fertility treatment cycle will be recorded separately in your patient chart.

ALLERGIES OR SENSITIVITIES:

MEDICATIONS, VITAMINS, SUPPLEMENTS:					***To be Completed by the Clinic***			
Name	**Dose**	**Route** (oral, patch, injection)	**Frequency** (daily, twice a day)	**Date Started** (DD-MMM-YY)	**MD/NP Initials**	**Date Stopped** (DD-MMM-YY)	**MD/NP Initials**	**NOTES**

To be Completed by the Clinic
List Updated By:

Print Name:	Initials:	Signature:	Date: dd/mm/yyyy	Print Name:	Initials:	Signature:	Date: dd/mm/yyyy