

# IMPORTANT: Please complete at home and bring with you to The Surgical Suites on day of surgery.

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PATIENT'S CURRENT MEDICATION RECORD.** Please list all medications (prescriptions, over-the-counter, herbal, etc.) in all forms that you are currently taking. Clearly list the names as they appear on the product's packaging.

List all of your ALLERGIES: (food, medications, etc.)	My reaction(s) to this allergen is (are):

Please check if more **allergies** are listed on back of form.

<b>MEDICATION LIST</b>  NAME OF MEDICATION OR SUPPLEMENT	STRENGTH / DOSAGE (mg, ml, etc.)	How many times per day taken?	Check how you take						
			Pill	Injection	Cream	Inhaled	Drops	Liquid	

Please check if more **medications** are listed on back of form.

I do not know what medications I am currently taking.

I hereby acknowledge that the above list is accurate, complete and represents the medications that I am currently taking as of \_\_\_\_\_ (today's date.) Should this document need to be transmitted to (shared with) another healthcare provider as part of my continuing medical care, I hereby authorize its release to those health care providers to which I have need transferred. This is protected health information and shall be treated accordingly.

