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.

MEDICATION LIST **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.

_____

PATIENT SIGNATURE DATE

Continued:

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

MEDICATION LIST 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