Surgical Associates

PATIENT HOME MEDICATION RECORD

Please complete this form as accurately as possible. List all **prescription** medications, as well as **over-the-counter** medications such **as vitamins, pain medication, herbals**, including those taken "as needed". This information is required by the hospital prior to your surgical date. Failure to complete this form may result in the cancellation of your surgical procedure.

NAME:_____ **DOB**_____

List all medication allergies here:_____

List all medications currently taking here:

	TYPE	DOSAGE	AMOUNT	REASON
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

The above information is true, complete, and correct to the best of my belief.

_____ _____

(Signature of Patient or Guardian) (Date)

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