

MEDICATION LIST

Patient Name: _____

Please complete the following form in detail before your surgery appointment and bring this form with you to the surgery center. Be sure to include all medications including vitamins, herbs, and over the counter medications as well as prescription drugs and the amount and frequency in which you take them. If you are unable to complete this form, please take all of your medications to the surgery center the day of surgery for assistance.

	Name of Medication	Dosage/Strength	Directions/ How often used
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Verified: _____

Verified: _____

Verified: _____

Verified: _____

Verified: _____
AAAHC REQUIREMENT 6/01

Verified: _____