Crown Valley
OUTPATIENT
SURGICAL CENTER

Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth:

MEDICATIONS LIST

Please list the medications you currently take

Name:_____ **Date:**_____

Allergies: (Medications/Food)_____

Abnormal reactions to medications: _____

These are the current medications I am on:

Medication:	**Dose (strength)**	**Frequency** (how often you take it)	**Route** (by mouth, IV)	**Reason You Take This**
Reviewed by:			Date:	
My medications list was reviewed with a Center staff member:				
			Patient signature	Date