Allergies / Sensitivities: (food, medications, latex, etc.) ☐ NKA

Name	Type of Reaction	Name	Type of Reaction
1)	1)	4)	4)
2)	2)	5)	5)
3)	3)	6)	6)

MEDICATIONS, OTC, HERBALS WITH DOSE	DOSE FREQUENCY	REASON for TAKING DRUG	PRESCRIBING PHYSICIAN	LAST DOSE DATE	Hold / Comment
New Medications					

PATIENTS:

1.) Always keep this form or a similar copy of your daily medications with you. Take it to all of your doctor and medicaltesting appointments.
2.) Update the form as changes are made to your medications. If a medication is stopped, draw a line through it and record the date it was stopped. Add new medications to the bottom or back of the form.
3.) Discuss any over the counter or herbal medications with your physician before taking them.
4.) Continue all medications unless otherwise noted.

Nurses Signature: _____

Date: _____

☐ **I have received a copy of my medication list.**

Patient Signature: _____

Date:

COAST SURGERY CENTER

PATIENT MEDICATION LIST

NAME:
ACT#:
DOS:

DOB: **AGE:**