PARKWAY SURGERY CENTER

PATIENT **ALLERGY** & CURRENT **MEDICATION** LIST

Name_____

Please complete the following information. A Registered Nurse will review this list and update it, if needed, when you arrive for your surgery or procedure.

ALLERGY(S): NONE_____ (please check none) or list:

Source of Allergy	Reaction	Source of Allergy	Reaction
Example : Penicillin	Hives	3.	
1.		4.	
2.		5.	

MEDICATION(S): NONE_____ (please check none) or list:

MEDICATION -List the names of any medications you are taking. Please include any over the counter medicines (vitamins, minerals, and herbal supplements). Also, include any medications you held for your procedure.	**STRENGTH** -List the strength of each tablet, capsule, etc.	**DOSE** -How much are you taking? (number of tablets, capsules, units, etc.)	**FREQUENCY** -How often do you take the medication? (daily, twice a day, monthly, etc.)	**ROUTE** -How are you taking this medication? (by mouth, injection, patch, etc.)	**LAST DOSE TAKEN** -Indicate the date and time of the last dose taken
Example : Toprol XL	100 mg	1 tablet	every day	by mouth	this morning
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Patient Signature: _____ Date _____

Reviewed by MD/RN: _____ Date _____

□ **NO CHANGES**: Date_____

_____PT Initial

_____RN Initial

PATIENT STICKER