

Please list all current medications you are taking, including prescription, non-prescription, and/or herbal supplements.

I do not take any medications

Patient Name : _____

ALLERGIES TO MEDICATION:

Medication Name:	ALLERGIC REACTION: (What happens when you take/come in contact with this medication?)
1.)	<input type="checkbox"/> RASH <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____
2.)	<input type="checkbox"/> RASH <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____
3.)	<input type="checkbox"/> RASH <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____
4.)	<input type="checkbox"/> RASH <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____
5.)	<input type="checkbox"/> RASH <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____

Current Medications:

Medication Name:	Dosage:	Times taken per day	How Long?	Last Taken:
1.)				
2.)				
3.)				
4.)				
5.)				
6.)				
7.)				
8.)				
9.)				
10.)				
11.)				
12.)				
13.)				
14.)				
15.)				

Medication information source: Patient Family Member Other: _____

Patient is compliant and taking medication as prescribed: YES NO

Patient brought medications with them for review: YES NO

Reviewed Day of Surgery by: _____ Date: _____

** TO BE COMPLETED BY PACU RN: ** PRESCRIPTIONS GIVEN AT DISCHARGE:				
Medication Name:	Dosage:	Times To Be Taken Per Day	For How long?	
1.)				
2.)				

Medications reviewed at discharge: _____

RN signature