

Patient Name: _____

Date of Birth: _____

List any known allergies and all of the following that you take on a regular basis at home:

- Prescription medications - over-the-counter medications - herbal and dietary supplements
- Vitamins - pumps, patches, or inhalers - drops, sprays, or ointments

Allergies: No Known Drug Allergies

Home Medication Name (include strength)	Directions (dose, route, frequency)	Reason for Taking	Last Dose Taken (date and time)
<input type="checkbox"/> Nothing taken on a regular basis.			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

Staff Use Only: Please do not write below this line.

Nurse Reviewing: _____ / _____
Signature date

Prescriptions Given at Discharge from Conroe Surgery Center

Medication	Directions	Reason for Taking	Next Dose

Copy given to patient at discharge.

Please refer to your Primary Care Provider or the ordering physician if you have questions about resuming any specific medication.

-patient -