

Patient Name _____ Date of Birth _____ / _____ / _____

Procedure Date _____ Scheduled Procedure Time _____

Dear Patient:

To help us better serve you, we will need you to provide us with a list of your current medications, including any over-the-counter medication you may be taking. This information is very important.

Please complete the list below and **BRING IT WITH YOU AT THE TIME OF YOUR PROCEDURE.**

Thank You.

	<u>Prescription / Medication</u>	<u>Dosage</u>	<u>Frequency(how often)</u>	<u>Reason for Medication</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

- If more space is needed, please continue on the back of this form.

Signature/Date of person Reviewing Medication List

_____ Date _____

