Patient Home Medication List*

**Home Medication List is as provided by the Patient*

(including prescriptions, over the counter, herbals, vitamins and birth control pills or patch)

ALLERGIES:

Medication Name	Dose	Frequency (how often?)	Reason for Taking	Last taken (date/time)	Instructions ********** (see below)

******** Contact your prescribing physician for questions regarding above medications ********

New Prescriptions	Dose	Frequency (how often?)	Reason for Taking	Last Taken (time if applicable)	Instructions	Next Dose @ (after discharge)

Pre-Op Nurse: _____

Copy given to patient upon discharge by PACU Nurse: _____

Patient Sticker