Patient Home Medication List

Please list all medications you are currently taking including all over the counter, vitamin or herbal supplements. Your accuracy in listing the medication name, dosage and frequency (how often or when you take it) are critical. This list will be used to guide the physician in prescribing the medications that you are given while in the hospital.

Medication Name	**Dosage**	**Frequency**	**Reason Taking Med**	**Comments** Please list any other pertinent information about how you take this medication
Over the Counter, Vitamin or Herbal	**Dosage**	**Frequency**	**Reason Taking Med**	**Comments**

Patient Name: ____________________________________

Patient Signature: _________________________________

Primary Physician: _________________________ **Primary Pharmacy:** ______________________________

Please complete this form and bring it with you to your Preop appointment with your physician. Thank you.