PATIENT MEDICATION LIST **Patient Name:** _____

Date Of Surgery: _____

Medication or Supplement	Dosage or amount taken	How taken	How often taken
Example: Aspirin	Example: 81 mg.	Example: Orally	Example: once a day

I have had allergic reactions to the following drugs:		Drugs	Reaction

I take no medications _____

PASC Folder, ASC Forms, QARM, Patient Medication List Form 03/08jm

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