SURGICAL ARTS CENTER

Patient Medication List

Patient's Name: _____ Date of Birth: _____

Allergies: _____

_____

_____

	Medication/Vitamin/Supplement	Dose	Frequency	Purpose
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				

WEIGHT LOSS MEDICATIONS MUST BE LISTED EVEN IF PATIENT STOPPED TAKING PRIOR TO SURGERY

Signature of Patient or Authorized Representative: _____ Date: _____