PATIENT MEDICATION INVENTORY

Patient Allergies	
Name of Med	Reaction

Anti-Coagulants (Blood Thinners)					Continue Medication after Discharge	
Name of Med	Dose	Schedule	Form	Last Taken	Yes	No
					❑	❑
					❑	❑
					❑	❑

Prescription Medication List					Continue Medication after Discharge	
Name of Med	Dose	Schedule	Form	Last Taken	Yes	No
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

Over the Counter Medications and Nutritional Supplements					Yes	No
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

Pre-Op Nurse:_____ Date:_____

Prescriptions Provided to Patient				
Name of Med	Dose	Form	How Often	Reason for Medication

***** PLEASE FOLLOW-UP WITH YOUR PHYSICIAN REGARDING YOUR MEDICATIONS *****

Post-Op Nurse: _____ Date:_____

Copy given to patient: ☐