Northwest Michigan
Surgery Center
Partnering with MUNSON HEALTHCARE

# Medication and Allergy List

**PLEASE COMPLETE AND BRING THIS WITH YOU ON THE DATE OF YOUR PROCEDURE.**

**Name:** _____ **Birthdate:** _____

**Please include vitamins and herbal medications as well as meds prescribed but not taken.**

| Medication Name | Dosage | Frequency (how often taken) | Taken on DOS? (TO BE COMPLETED BY SURGERY CENTER STAFF) DOS: _____ | Taken on DOS? (TO BE COMPLETED BY SURGERY CENTER STAFF) DOS: _____ |
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| Medication Allergy | What happens? |
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Confirmed with patient _____ DOS: _____
**Nurse Signature**

Confirmed with patient _____ DOS: _____
**Nurse Signature**