OAK PARK SURGERY CENTER

Medication List

Patient: _____ M / F _____ Age: _____

Please list all medications that you will have taken within 2 weeks before the scheduled surgery:

Medication	Dose/Mg	Times per day	Reason

Medication you are allergic to:

Medication	Reaction

Allergic reactions to: Latex: No: _____ Yes: _____
Foods: No: _____ Yes: _____
Tapes: No: _____ Yes: _____
Iodine: No: _____ Yes: _____
Other: _____

Patient Signature: _____Date:_____