PATIENT STICKER
EFFECTIVE 01/2016
REVISED 03/2016

ST. GEORGE SURGICAL CENTER

# MEDICATION / ALLERGY HISTORY FORM

| **Patient Name:** _____ | **Allergic reaction to:** (Include drugs, food, vaccines, latex, dyes, etc.) | **Describe Allergic Reaction:** (Including unknown) |
|---|---|---|
| **Form filled out by:** | ☐ **No known Allergies** | |
| ☐ **Patient** | | |
| ☐ **Spouse**_____ | | |
| ☐ **Family Member:**_____ | | |
| ☐ **Other (Specify):**_____ | | |
| **Patient's Home Pharmacy:** | | |
| _____ | | |

**INSTRUCTIONS: Include:** **Prescriptions** **Over-the-counter Medications** **Patches** **Inhalers**
**Vitamins** **Herbal / home remedies** **Teas** **Dietary supplements**

| **Medication** (Including dosage & form if indicated, such as: EC, XL, ER, SR, CD, XR) | **Dose** (amount) | **Route** (oral, topical, inject, etc.) | **Schedule** (How often do you take it?) | **When last taken** | | **Reason for Taking** (ie- diabetes, high blood pressure, diuretic, cholesterol, etc) |
|---|---|---|---|---|---|---|
| | | | | **Date** | **Time** | |
| ☐ **None** | | | | | | |
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**I attest that all Allergies & Medications have been reviewed with the Patient**

**PRE-OP NURSE SIGNATURE:** _____ **DATE:** _____