Central Arkansas Surgical Center

Medication and Allergy Sheet

Please complete this record. A copy of this record will be given to you at the time of discharge from our Center. For your safety and convenience keep a copy with you at all times.

List all Allergies: Medications, Foods, Metals, and Latex

Allergy:_________________Reaction:_______________ Allergy:________________Reaction:_________________
Allergy:_________________Reaction:_______________ Allergy:________________Reaction:_________________

Medications: *****Please list all medications prescribed, over the counter, and herbal that you have taken in the last 30 days.***

Medication	Dose/ Strength	How often	Reason for taking	Medication	Dose/ Strength	How often	Reason for taking

Patient Signature________________________Date___________ Nurse Initials__________Date_______________

(For Future Visits ONLY)
The above list has been updated and reviewed for medication changes and is accurate to the best of my knowledge.
Patient Signature________________________Date___________ Nurse Initials__________ Date_____________
Patient Signature________________________Date___________ Nurse Initials__________ Date_____________

*= Patient unable to provide complete information regarding home medications when asked by nurse or physician.

New Prescriptions (Will be completed at the time of discharge).

Medication	Dose/Strength	How often	Reason for taking this Medication	Date Issued

This medication and allergy form has been provided as a patient education and safety service of the Central Arkansas Surgical Center.