Conroe Surgery Center **Home Medication List** **Patient Label**

Patient Name: _____Date of Birth: _____

List any known allergies and all of the following that you can take on a regular basis at home:
- prescription medications - over-the-counter medications - herbal and dietary supplements
- vitamins - pumps, patches, or inhalers - drops, sprays, or ointments

Allergies: ☐ No Known Allergies

_____

Home Medication Names	Directions (dose, route, frequency)	Reason for taking	Last dose taken (date and time) 1st Visit	Last dose taken (date and time) 2nd Visit
☐ Nothing taken on a regular basis.				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patient 1st Visit(Signature/Date):_____ **Nurses**(Signature/Date):_____/_____
Nurse Completing Form Nurse Reviewing

Patient 2nd Visit(Signature/Date):_____**Nurses**(Signature/Date):_____/_____
Nurse Completing Form Nurse Reviewing

Prescriptions Given at Discharge from Conroe Surgery Center

Medication	Directions	Reason for Taking	Next Dose

_____ Resume all meds as prescribed **(1st Visit)** _____Resume all meds as prescribed **(2nd Visit)**

_____

☐ Copy given to patient at discharge **(1st Visit)** ☐ Copy given to patient at discharge **(2nd Visit)**
Please refer to your Primary Care Provider or the ordering physician if you have any questions about resuming any specific medication.

Discharge Nurse reviewing **1st Visit**(Signature/ Date): _____/_____

Discharge Nurse reviewing **2nd Visit**(Signature/ Date): _____/_____

Must use new form after 30 days of last visit