TRUVISTA SURGERY CENTER

Patient Name: _____ Date: _____

MEDICATION FORM: Please fill out this form with all the medications you take. Example: prescriptions, samples, vitamins,nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents,radioactive meds, respiratory therapy-related meds, parenteral nutrition, blood derivatives and IV solutions, and any product designated by FDA as a drug.

MEDICATION	DOSE	HOW OFTEN	What drug is used for?