Hillside Surgery Center
care with you in mind™

Please complete this form and bring day of surgery/procedure.

MEDICATION AND ALLERGY LIST

Name: _____

Date of Birth: _____

Source of information:

- ☐ Patient _____
- ☐ Family member _____
- ☐ Provider office _____
- ☐ Other: _____

Allergic To	Describe Reaction	Allergic To	Describe Reaction

Please list the medications you are taking, including over-the-counter medications & herbal supplements.

CURRENT MEDICATION				
Resume At Discharge	Name of Medication	Dosage/Strength	Time Taken	Reason for Taking
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				
☐ YES ☐ NO				

PRESCRIPTION WRITTEN BY SURGEON DAY OF SURGERY	
Medication	Indication

Name of Pharmacy you use:_____Phone #:_____

Name of Primary Care Physician:_____Phone #:_____