Metro Anesthesia & Pain Management

Home Medication Summary

NAME_____ DOB_____

ALLERGIES AND REACTIONS –Please list medication/environmental allergies and reaction (rash, hives, difficulty breathing, etc)

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Please list all of your medications (including over the counter medications and herbal supplements), the dose, and the frequency with which you take them.

MEDICATION	DOSE	FREQ.	Date	Updated	Updated	Updated	Updated