Patient Medication List

*Please list **ALL** medications that you currently take (including over the counter, eye drops, and ointment), dose or strength, and the last date it was taken. Please complete this form and bring it with you on the day of surgery.*

MEDICATION NAME (Additional space on reverse)	**DOSE**	**FREQUENCY**	**DATE LAST TAKEN** (1^{ST} Visit)	

STAFF USE ONLY BELOW THIS LINE

Pre-Op Nurse to verify medication list.	Noted By:	Noted By:
Bottom Section to be completed in the Recovery Room		
Medications given at facility that may alter gait or cause dizziness: ❑ Midazolam ❑ Fentanyl ❑ Alprazolam ❑ Other: _____		
Resume all medications listed above Except: Begin post-op drops – See attached drop schedule or as directed in MD instructions Continue glaucoma drops in OPERATIVE EYE Continue glaucoma drops in NON OPERATIVE EYE	❑ _____ ❑ ❑ YES ❑ NO ❑ YES ❑ NO	❑ _____ ❑ ❑ YES ❑ NO ❑ YES ❑ NO
Prescriptions Given at Discharge: Erythromycin Ophthalmic Ointment _____	 ❑ ❑	 ❑ ❑
Medication Reconciliation Completed	By: ❑ Copy Given to Patient	By: ❑ Copy Given to Patient

_____

Patient Name (print)

Patient Sticker

MEDICATION NAME	DOSE	FREQUENCY	DATE LAST TAKEN (1ST Visit)	