SWGA
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Patient Medication History Form

The medicines you take are part of your health information. Please fill out this form and bring it with you to your procedure appointment. If you need space to list your medicines, you may list them on the back of this form.

Patient Name:_____ Date of Birth: _____

- **Drug Allergies** **Check if None** ☐

Name of Substance	Type of Reaction

- **Current Medications** **Check if None** ☐

Prescription Drugs (i.e. Atenolol, eye drops, creams)	**Strength** (i.e. 50mg)	**Directions** (Such as 2 tablets in the a.m.) Check box if taken as needed.	**Date of last dose**
		☐	
		☐	
		☐	
		☐	
		☐	
Over the Counter Medication (i.e. aspirin) Check if none	**Strength**	**Directions**	**Date of last dose**
☐			
		☐	
		☐	
		☐	
Herbs, Vitamins, Minerals, Etc. (i.e. St. John Wart) Check if none ☐	**Strength**	**Directions**	**Date of last dose**
		☐	
		☐	
		☐	
		☐	
		☐	

Pharmacy Name:_____ Phone Number: _____

Patient Signature:_____ Date: _____