



BUFFALO SURGERY CENTER

Medication History

(Medication Reconciliation Form)

*Please list below ALL of the patient’s medications including all over the counter medications, vitamins and herbs.

Allergies _____

Height _____ Weight _____

Medication Name	Dose	How Often	Route (oral, IV, patch)	Indication	Hold for surgery	Advised to take day of surgery	Last dose	Comments
1)								
2)								
3)								
4)								
5)								
6)								
7)								
8)								
9)								
10)								
11)								
12)								
13)								
14)								
15)								
16)								

(If not enough room for all of your medications please continue on the back)

Patient’s signature _____ Date _____ RN’s Signature _____ Date _____

Patient’s signature _____ Date _____ RN’s Signature _____ Date _____

Patient’s signature _____ Date _____ RN’s Signature _____ Date _____

****Please return to the Buffalo Surgery Center as soon as possible! Thank you for your cooperation!****