UCLA Health

MRN:

Patient Name:

MEDICATION HISTORY FORM
AMBULATORY SURGERY CENTER

Please list all the medications you are currently taking at home. Please include prescription medications, non-prescription "over-the-counter" medications, vitamins, herbals, and supplements.

Patient Name (please print): ___________________________ Date: __________ Time: ______

Allergies:____ Height: ________ Weight: ______

☐ Not taking any medications at home.

Prescription Medications (Please write clearly using ink.)				
Medication	Dose	Directions for Use (How often are you taking it?)	Time/Date of last dose	
			Time	Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
Over-the-counter Medications, Vitamins, Herbals and Supplements				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				