

Genesee Surgical Associates, P.C.
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Name: _____ **Date of birth:** _____

Date: _____

MEDICATION LIST

(Include ALL medicines taken including prescription, nonprescription, vitamins, herbals, aspirin, etc.)

Medications: Generic name(brand)	Strength/ dosage	Directions	Time(s) taken	Purpose of medication
<i>Example: Lovastatin (Mevacor)</i>	<i>20 mg</i>	<i>one tablet daily</i>	<i>6pm</i>	<i>high cholesterol</i>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Are you allergic to LATEX? YES NO

Are you allergic to any medication? YES NO
(If circling "YES", please describe below)

Allergies	Brief description of reaction

Please list all physicians involved
in your current care:
