SOUTHERN SURGICAL HOSPITAL
PATIENT MEDICATION RECORD

*If patient medication list is longer than space provided, please use 2nd sheet
White background area to be completed on admission
Gray background area to be completed on discharge

Ht. __________ Wt. _________ Lactating ____Yes ____No Pregnant ____Yes ____No

Prior to Arrival						During Hospitalization		On Discharge				
MEDICATION Taken at Home (also include Vitamins, Herbal, and other Over the Counter Medication)						HOME MEDICATION		Continue HOME MEDICATIONS				
MEDICATION Ordering Physician	DOSE	FREQUENCY	LAST DOSE DATE/TIME		Reason for Med	Cont. during hospitalization?		Cont. on Discharge		DOSE	FREQUENCY	Next Dose Due
ASPIRIN Yes No		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	
		______ times per day other__________				yes	no	yes	no		______ times per day other__________	

MEDICATION/FOOD ALLERGIES
NAME REACTION
NAME REACTION
NAME REACTION
NAME REACTION
NAME REACTION
NAME REACTION
NAME REACTION

NEW MEDICATIONS ON DISCHARGE			
MEDICATION	DOSE	FREQUENCY	Reason for Med
		__________times per day other__________	
		__________times per day other__________	
		__________times per day other__________	
		__________times per day other__________	

Physician Signature ______________________________ Date/Time ______________

This is a complete list of the patient's medicines: Yes No

Who provided the medication information? ______________________________

A member of the patient's family will bring a list: Yes No

Name: ______________________________ Phone No: ______________

Signature of Nurse admitting patient ______________________________ Date

Signature of Nurse discharging patient ______________________________ Date

Patient Acknowledgment ______________________________ Date

SOUTHERN SURGICAL HOSPITAL

SSH-NUR003 09/11

PATIENT MEDICATION RECORD

White - Chart Yellow - Patient

Patient Label