VCU Medical Center
Virginia Commonwealth University

Neurosurgery (Medicine/Allergy list)

Name:_____ MR#:_____ Attending:_____

Allergies

MEDICINE	WHAT REACTION DO YOU HAVE?

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Medications

NAME OF MEDICINE	STRENGTH (DOSE) (MG)	NUMBER OF PILLS	TIMES PER DAY TAKEN (Circle one or indicate how often you take your medicine)	AS NEEDED
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Date Reviewed