CHESAPEAKE REGIONAL
MEDICAL CENTER

Pre-Surgical Admission
Medication List

Name _____ Date of Birth_____

Please list all medications, including over the counter medications and vitamins. The list should include any pain medications or medications you use occasionally. If you have a current list, you may provide that instead of re-writing all the medications.

Name of Medication	Dose	How often
EXAMPLE: Pepcid	***10mg***	***Once a day***