WakeMed

Patient Name___________________________________ **Date of Birth**_______________________________

It is important for WakeMed to verify your medications upon arrival and again at discharge.

Allergies (Include medications, latex, X-Ray dyes, seafood, and other foods,etc.) ☐ **None**	**REACTION**

Current Medications(Include vitamins, supplements, herbs & over-the-counter) ☐ **None**	**Dose as taken**	**Frequency**	**Last Taken (Date/Time)**	**Reason per patient**

Please bring all medications you are now taking with you and the original containers.

Past Procedures and Major Surgeries : Please list all cardiac tests(stress test,echo,etc.) and procedures.	**Month/Year**	**Where**

Name of Pharmacy	**Phone #**

Name of Physicians	**Phone #**