NAME: _____

Place sticker if available

DOB: _____ AGE: _____

# MEDICATION LIST

Please check location:

**SCHC RADIOLOGY** ☐ BEND ☐ RDMD ☐ PV ☐ MADRAS ☐ **CMI** ☐ **HEART CENTER**

**PATIENT or RESPONSIBLE PARTY TO COMPLETE:**

Do you have any DRUG and/or CONTRAST Allergies? ☐ Yes ☐ No

If you answered YES, please list the DRUG and REACTION: _____

**PATIENT or RESPONSIBLE PARTY TO COMPLETE:**

List all current medication (or HELD for this procedure) including vitamins and herbal supplements

EXAMPLE: Medication, Dose, Route > Lasix 10mg oral

| Medication | Dose | Route |
|---|---|---|
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**Patient Signature or Responsible Party Signature:** _____