Medicine List
Spine Prehab

HENRY FORD HEALTH

Fill this out and bring it with you to the hospital on the day of surgery. **Do not bring your medicines to the hospital.**

Name: _____ Date of Birth _____

Allergies: _____

Pharmacy: _____ Pharmacy Phone: _____

Prescription Medicine

For example: eye drops, patches, inhalers, pumps, etc.

Medicine Name	Dose (ex. 20 mg tablet)	How often do you take? (ex. 3 times a day)	Last dose taken?

Over-the-Counter Medicine

For example: supplements, herbs, vitamins, etc.

Medicine Name	Dose (ex. 20 mg tablet)	How often do you take? (ex. 3 times a day)	Last dose taken?