Patient Name: _____

Gender: ❑ Male ❑ Female Date of Birth: _____

Please list all medications.

Medication	Dose	Frequency	Indication	Prescribing Physician	Date confirmed or updated					Initials

Please list all allergies.

Form reviewed by _____ Date _____ Time _____

Initials	Signature	Initials	Signature	Initials	Signature

Bryan Medical Center
Lincoln, NE

BARIATRIC SERVICES
MEDICATIONS AND ALLERGIES

Place Patient Label Here