



JOHN WAYNE CANCER INSTITUTE
AT ST. JOHN'S HEALTH CENTER

**LIVER AND PANCREAS CENTER
GASTROINTESTINAL SURGERY**

MEDICATION LIST

NAME: _____

Please attach a list of all your medications, or fill out a medication list below.

| | | |
|--|---------|-------|
| DO YOU HAVE ANY ALLERGIES: | YES/ NO | LIST: |
| If yes: What kind of reaction do you have? | | List: |
| Are you on any blood thinning medications or anti-clotting medication? | Yes/ No | List: |

| MEDICATION | DOSE | FREQUENCY |
|------------|------|-----------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |