OAKLAWN SPORTS REHABILITATION CENTER
Medication/Surgery List

Name: _____ **Age:** _____
Date of Birth: _____ **Sex:** □ **Male or** □ **Female**

Are you allergic to latex? YES or NO
Do you have a pacemaker? YES or NO

Current Medications (ONE PER LINE)

Medications	**Reason for use**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any additional medication on back of this sheet

Previous Surgeries

Surgical History
Please list surgeries/include dates if known (within last 5 years)

_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____