Diagnostic Endoscopy Center, LLC

PATIENT MEDICATION HISTORY FORM—PAST 30 DAYS

PATIENT INFORMATION: **Fill in this allergy and medication section only.**
Please complete this form and bring it with you on the day of your procedure.

Name: _____ Birthdate: _____

Emergency Contact: _____ Phone: _____

☐ No Allergies	
Allergic To:	**Reaction**

Name of Medication/ Vitamins/OTC	Dose	How Often Taken	Last Date & Time Taken	Reason	Prescribed by:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

Post Procedure Physician Medication Instructions

Resume		
Yes	**No**	**Hold**

PHYSICIAN DOCUMENTATION — NOTES:

Endoclip was used today: ☐ Yes

If yes, an MRI should not be done for _____ weeks.

Call me if an MRI must be performed during this time frame.

Avoid aspirin, Advil, Motrin, Ibuprofen, Vit. E, Vit. C, Aleve, Excedrin,...for _____ **days**

Blood Thinner: _____ **Resume date:** _____

New medication(s) added today: ☐ Yes

Sign: _____ **, MD Date:** _____

NURSING DOCUMENTATION:

Today, you had the following procedure: ☐ Colonoscopy ☐ Gastroscopy ☐ Flex Sigmoidoscopy Other _____

You were given the following medications: ☐ Propofol/Lidocaine 2% ☐ Propofol ☐ Versed ☐ Fentanyl ☐ Gas X ☐ Zofran Other _____

Pt Initial: _____ Nurse Initial: _____ Date: _____