Green Spring Station Endoscopy Patient Medication List

PLEASE BRING THIS COMPLETED FORM TO YOUR PROCEDURE

List all your allergies to MEDICINES/ FOOD / OTHER and describe the reaction

Allergy/Sensitivities	YES	NO	Reaction	MEDICATION ALLERGIES	REACTION
LATEX					
PEANUTS					
EGGS					
SOY					
SULFITES					

List all medications that you take: PRESCRIBED, OVER THE COUNTER, AND ANY HERBAL MEDICATIONS
If you use an inhaler, please bring it with you.

MEDICATIONS

Name of Medication	Dosage	Frequency	Last dose	Reason for medication	Resume (For Nurse only)

(Nurse to complete this section)

New medications your doctor wants you to begin taking.

Name of Medication	Dosage	Frequency	Start date	Reason for medication

_____ _____

PATIENT'S SIGNATURE **Date** Nurse's Signature Date

_____ _____

Nurse's Signature Date Physician's Signature Date