Gastroenterology Associates - Endo Medication List

Patient: ______________________ Phone: ______________

DOB: ______________________ Age: ______________ Cell: ______________

Referring Dr. ______________________ Date: ______________ Attd: ______________________

Date of Proceedure: ____

PLEASE LIST ALL MEDICATIONS, DOSAGE AND FREQUENCY TAKEN

Over the Counter Medications:

NAME	DOSE	FREQUENCY	LAST DATE TAKEN

Prescription Medications:

NAME	DOSE	FREQUENCY	LAST DATE TAKEN

MEDICATION RECONCILIATION (Endo Center Use)

_____ Continue Home Regimen ______________________________________

_____ Stop Taking ______________________________________

_____ Hold ______________________________________

_____ Begin Taking ______________________________________

_____ R.N. ______________________________________