PALM ENDOSCOPY CENTER
PATIENT MEDICATION LIST

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YOUR MEDICATIONS MUST BE LISTED ON THIS FORM.
WE CANNOT ACCEPT ATTACHMENTS – DO NOT SUBMIT YOUR OWN LIST

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NAME_____________________________________ DATE OF BIRTH_________________________

PRIMARY/REFERRING MD___________________________

Please list all medications you take on a regular basis, including prescriptions, herbal supplements, vitamins, and over the counter medications. **Bring this form with you on the day of your procedure.**

Name of Medication	Dosage (mg)	How many times per day	Date last taken	May resume after procedure
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

☐ Reviewed with patient _________________________Pre-Op Nurse

☐ Copy given to patient _________________________Discharge Nurse

☐ Reviewed by anesthesia_________________________

Date_____________________________

02/12