Gastroenterology Specialists of Gwinnett, PC

MEDICATION LIST

Name:_____ Date of Birth: _____ Date: _____

ALLERGIES *(to medications, injections, environmentals, etc.)*

☐ Check box if you **DO NOT** have any Allergies.

Medication	Reaction

☐ Check box if you **DO NOT** take any medications.

For Northeast Endoscopy Center use Only

Current PRESCRIPTION Medications

Name	Dosage	How Often?	Last Taken	Continue	
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N

Current Over the Counter *(Aspirin, Motrin, Vitamins, etc)*

Name	Dosage	How Often?	Last Taken	Continue	
				Y	N
				Y	N
				Y	N
				Y	N
				Y	N

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New Medications to take/Additional Notes:

PRE PROCEDURE RN:	**Date:**	**Time:**
POST PROCEDURE RN:		

Medication reconcilliation reviewed verbally and signed copy given to patient.