Endoscopy Center

Patient Information Form

PATIENT NAME: _____ **DATE COMPLETED:** _____

MEDICATION LIST: *List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, Albuterol, Nitroglycerin). Write additional medications on reverse side.*

Medication Name (Brand or Generic)	Dose	Frequency (How Often Taken)	Reason for Taking	Date of Last Dose

ALLERGIES **No:** _____ **Yes:** _____ If yes, list all allergies (medications, food, latex, etc.)

Allergy	Reaction		Allergy	Reaction

PREVIOUS SURGERIES **No:** _____ **Yes:** _____ If yes, please list all previous surgeries and approximate date.

Date	Type of Surgery		Date	Type of Surgery

Patient Signature: _____ Reviewed By RN: _____