

# Southwest Endoscopy Patient Medication History Form

The medicines you take are part of your health information. Please fill out this form and bring it with you to your procedure appointment. If you need more space to list your medicines, you may list them on the back of this form.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## ■ Allergies

Name of Substance	<input type="checkbox"/> Check if none	Type of Reaction

Do you react to latex or rubber (gloves, balloons, etc) with a rash, wheezing, etc?  Yes  No

For female patients ONLY: Are you currently pregnant?  Yes  No

Are you considering becoming pregnant?  Yes  No

Are you currently breastfeeding?  Yes  No

## ■ Current Medications

Prescription Drugs (i.e. Atenolol, eye drops, creams) <input type="checkbox"/> Check if none	Strength (i.e. 50 mg)	Directions (such as 2 tablets in the a.m.) Check box if taken only as needed.	Prescribed By (such as John Doe, MD)
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
Over the Counter Medications (i.e. aspirin) <input type="checkbox"/> Check if none	Strength	Directions (such as for headaches when needed)	
Herbs, Vitamins, Minerals, Etc. (i.e. St. John's Wort) <input type="checkbox"/> Check if none	Strength	Directions (such as one tablet each day)	

Pharmacy Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medication History Form reviewed by Physician prior to procedure \_\_\_\_\_ (physician initials)