

St. George Endoscopy
Center

THIS FORM MUST BE
FILLED OUT PRIOR TO
YOUR
VISIT OR YOUR
PROCEDURE MAY BE
CANCELLED

Medication Allergies:

Medication History- Including over the counter medications

Medication Name	Dose	Route: Oral Injection Sublingual	Frequency	Last Dose Taken

Comments:

FOR OFFICE USE ONLY

Medication/ Allergy History
Provided by:

Interviewer:

Date:

*Signature Review of medications and
allergies across the patient care
continuum*

Procedure Nurse:

Discharge:

Resume all Pre-op medications at the same dose and frequency.

Exceptions/Explanations:

Additional home medications for patient discharge:

Medication Name	Dose	Route	Frequency	Rx Given?

Physicians Signature:

Date: