WEYMOUTH ENDOSCOPY, LLC

PATIENT MEDICATION HISTORY FORM

Name:_____Date of Birth:_____

Date of Exam: _____

**Please mail back with packet*

Daily Medications Taken: **No** ☐ **Yes** ☐

Allergies / Sensitivities and Reactions:

_____

_____

Name of Medication/Vitamin/OTC	**Dose**	**How often taken**	**Last dose taken**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No** ☐ **Yes** ☐ _____

New medication added today: **No** ☐ **Yes** ☐ _____

	YES	**NO**	**N/A**	**DATE**
Resume Aspirin	☐	☐	☐	_____
Resume Ibuprofen, Aleve, Excedrin	☐	☐	☐	_____
Resume Blood Thinners	☐	☐	☐	_____

MD signature: _____ Date: _____

Nursing Documentation: Today you had the following procedure:
Colonoscopy ____ Gastroscopy____ Flexible Sigmoidoscopy____

You were given the following medications:
Versed____Fentanyl____Demerol_____Zofran_____Other:_____

Endoclip was used today Yes ☐ - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ Date: _____