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				__________

Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _______ days

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: ___________________