WEYMOUTH ENDOSCOPY, LLC
PATIENT MEDICATION HISTORY FORM

Name: _____ Date of Birth:_____

Date of Exam: _____

**Please mail back with packet*

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** ☐ _____

	N/A	**Yes**	**Number of Days**
Hold Aspirin	☐	☐	_____
Hold Ibuprofen, Aleve, Excedrin	☐	☐	_____
Hold 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: Propofol __ Fentanyl __ Versed __ 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: _____