

Patient Name _____ Date of Birth: _____ / _____ / _____

Procedure Date _____ Scheduled Procedure Time _____

Medication Allergies _____

Dear GI Lab Patient:

To help us better serve you, we will need you to provide us with a list of your current medications, including any over-the-counter vitamins or herbs you may be taking. This information is very important.

Please complete the list below and **BRING IT WITH YOU AT THE TIME OF YOUR PROCEDURE.**
Thank you.

	<u>Prescription/Medication</u>	<u>Dosage</u>	<u>Frequency (how often)</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

*If more space is needed, please continue on the back of this form.

Signature/Title/Date of RN Reviewing Medication List

Addressograph

<p>GI OUTPATIENT MEDICATION HISTORY (Supplement to Sedation & Analgesia Flowsheet)</p>

St. John's Mercy Medical Center, St. Louis, MO