Medication List

Name _____ Date of Birth _____

Today's Date _____ Reason for Visit _____

Please complete the information below and <u>bring this form with you</u> on the day of your procedure.

List all current medications that you currently take, including vitamins, over-the-counter medications and herbal preparations.

Medication Name (Please Print Legibly)	Dosage (mg)	Frequency (How often per day)	Check if need refill

Name, phone #, and location of preferred pharmacy _____

_____

Do you have any allergies and if so, to what? _____

_____

If more space is needed, please use the back of this form.

↓This section to be completed by the Endocentre ↓

Medications Added After Procedure/Office Visit	Dose (mg)	Frequency (How often per day)
1.		
2.		

☐ Copy Given to Patient _____
Initials