PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

MEDICATIONS & ALLERGY FORM

PATIENT INFORMATION		
Name:	Date of Birth:	Current Age:
Today's date:	Pharmacy:	

☐ **See Attached Medication List**

PRESCRIPTION MEDICATIONS - CURRENTLY USING			☐ Not taking any prescription medication	
Medications	**Dose (How much?)**	**Route (How taken?)**	**Frequency (How often?)**	**Indication (What for?)**
Example: Nexium	*40 mg capsule*	*Orally*	*Once a day*	*Acid reflux*
Additional comment:				

OVER THE COUNTER (OTC) MEDICATION/SUPPLEMENT - CURRENTLY USING			☐ Not taking any OTC medication	
Medications	**Dose (How much?)**	**Route (How taken?)**	**Frequency (How often?)**	**Indication (What for?)**
Example: Advil	*200 mg tablet*	*Orally*	*As needed*	*Joint pain*
Additional comment:				

DRUG ALLERGY			☐ No known drug allergy
Medications	**Type of reaction**	**Medications**	**Type of reaction**
Example: Penicillin	*Rash*		
☐ Sulfa			
☐ Erythromycin			
☐ Penicillin			
☐ Latex			
☐ Tape			
☐ IV contrast			
☐ Demerol			
☐ Versed			
Additional comment:			

_____ _____

Signature of Patient/Guardian Date