CENTER FOR
DIGESTIVE HEALTH
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Board Certified, Gastroenterology

Patient Name: _____DOB: _____DATE:_____

Prescription Medication Name	**Strength** (mg, units, mcg)	**Number of times taken per day**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
Over the Counter/Non Prescription/ Herbal supplements or Remedies	**Strength** (mg, units, mcg)	**Number of times taken per day**
1		
2		
3		
4		
5		
6		

It is very important that we have an accurate medication list. Failure to provide this may result in an adverse or undesired outcome for you.