C E N T E R F O R
DIGESTIVE HEALTH
Michael P. Dohrenwend, M.D.
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.