GASTROENTEROLOGY
SPECIALISTS OF OREGON, P.C.

PATIENT: _____ APPT DATE: _____

PROVIDER: _____ CHART #: _____

List CURRENT Medications:

DATE/YEAR STARTED	COMPLETE NAME OF DRUG	STRENGTH	NUMBER AND TIMES PER DAY	PRESCRIBING DR.

List any ALLERGIES to Medications:

COMPLETE NAME OF DRUG	REACTION OR SIDE EFFECT

SIGNATURE: _____ DATE: _____