WEYMOUTH ENDOSCOPY, LLC.
PATIENT MEDICATION HISTORY FORM

Allergies / Sensitivities and Reactions:

_____

_____

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No** ☐ **Yes** ☐ _____

New medication added today: **No** ☐ **Yes** ☐ _____

	N/A	YES	Number of Days
Resume Aspirin	☐	☐	_____
Resume Ibuprofen, Aleve, Excedrin	☐	☐	_____
Resume Blood Thinners	☐	☐	_____

☐ Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _____ days

MD Signature: _____ **Date:** _____

Nursing Documentation: Today you had the following procedure:

Colonoscopy____ Gastroscopy____ Flexible Sigmoidoscopy____

You were given the following medications: Versed____ Fentanyl_____ Zofran_____ Propofol_____ Lidocaine____ Glycopyrrolate____ Other:_____

Endoclip was used today Yes ☐ - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ Date: _____