Dayton Gastro Endoscopy

(937) 320-5050
(800) 341-5055
www.daytongastro.com

Medications and Allergies - Please Print

Patient Info

Today's Date_____

Name *(First, Middle, Last)* _____ Date of Birth_____

Allergies/Reactions

Please list any allergies or reactions to medications, foods, latex or dyes.
Please list what type of reaction you experienced (example: difficulty breathing, hives etc.)

_____

_____

_____

Medications/Dosages

Please list all your medications and doses. Include vitamins, herbal supplements, and over-the-counter medications (for example: ibuprofen, Advil, Aleve, aspirin, Excedrin, Motrin, etc.).

Medication	Dosage	How Often Taken

Pharmacy

Please provide the following information for your preferred pharmacy.

Pharmacy Name _____ Address _____

Pharmacy Phone Number _____