Dayton
Gastroenterology, Inc.

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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.)

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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 ______________________