MEDICATION RECORD

GASTROENTEROLOGY ASSOCIATES

PATIENT: _____ **DOB:** _____

PREFERRED PHARM ACY NAME & ADDRESS: _____

PREFERRED PHARM TEL#_____

FAX#_____

MAIL-IN PHARMACY NAME & ADDRESS:

_____

ALLERGIES

Drug	Reaction	Drug	Reaction

MEDICATIONS

Start	Medication/Strength	Dose/Frequency	Refills				Stop

MEDICATION RECORD

GASTROENTEROLOGY ASSOCIATES