St. George Endoscopy
Patient Medication Reconciliation Form

Name:	Date of Birth:	Age:

Allergies: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency	Last Dose Taken

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Supplement (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency	Last Dose Taken

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency

Signature of Patient/Responsible Person: ____ **Date:** ___________________________

Nurse Signature: ________________ **Anesthesia Provider:** ___________________ **Physician Signature:** ____________________

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