



**Southwest Endoscopy**

7788 Jefferson Street NE, Albuquerque, NM 87109  
(505)999-1600 Fax: (505) 999-1650

**Patient Medication History Form**

The medicines you take are part of your health information. Please fill out this form and bring it with you to your procedure appointment. If you need space to list your medicines, you may list them on the back of this form.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

▪ **Drug Allergies** Check if None

Name of Substance	Type of Reaction

▪ **Current Medications** Check if None

Prescription Drugs (i.e. Atenolol, eye drops, creams)	Strength (i.e. 50mg)	Directions (Such as 2 tablets in the a.m.) Check box if taken as needed.	Date of last dose
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
Over the Counter Medication (i.e. aspirin) Check if none <input type="checkbox"/>	Strength	Directions	Date of last dose
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
Herbs, Vitamins, Minerals, Etc. (i.e. St. John Wart) Check if none <input type="checkbox"/>	Strength	Directions	Date of last dose
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_