Alabama Colon & Gastro, P.C.

Patient Name:_____DOB:_____Date:_____

Medications

Please list **ALL** current medications you are taking including
Vitamins, Herbals and Over the Counter Medications.

Medication	Dosage	Frequency	Reason for Taking

Medication Allergies

Medication Allergies:

- ❍ None

Latex Allergy: ___No ___Yes Reaction:_____

Medication	Reaction

Pharmacy Information

Please tell us the Pharmacy where you would like to use for your prescriptions.

Name of Pharmacy:_____

Address/Location of Pharmacy: _____

Phone Number of Pharmacy:_____