Texas Center For
DIGESTIVE HEALTH

Patient's Name:_____

CURRENT MEDICATION LIST

(Please list all prescription and over the counter medication including supplements)

1. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

2. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

3. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

4. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

5. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

6. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

7. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

8. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

9. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____

10. NAME OF MEDICATION/DOSE: HOW OFTEN DO YOU TAKE MEDICATION:

_____ _____