



Patient Medication List

*Thank you for choosing us to be your Center
for excellent Gastrointestinal care!*

GREGORY S. SMITH, M.D.
Board Certified Gastroenterology & Hepatology

Patient Name: _____ Date of Birth: _____

Please list current medications you are taking, including: Prescriptions, over-the-counter, Blood- Thinners,
Laxatives, Vitamins, Herbals, or Ointments:

| Medication | Dosage | Method | Frequency (how often) |
|---------------------------|---------------|--------------------|-------------------------------|
| <i>Example: Nexium</i> | <i>20 mg</i> | <i>tablet</i> | <i>twice a day</i> |
| <i>Example: Dulcolax</i> | <i>10 mg</i> | <i>suppository</i> | <i>once a day as needed</i> |
| <i>Example: Melatonin</i> | <i>2.5 mg</i> | <i>oral liquid</i> | <i>once a day at bed time</i> |
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Created kp.01.2019

Drug Allergies: _____ No known Drug Allergies: (check box)
 Other Allergies including metal: _____ No known Food Allergies: (check box)

Please make sure you have your gastroenterology-related records with you or have your provider fax to 706-548-0555.