# ENDOSCOPY CENTER OF TOPEKA

## Patient Medication History

Name _____ Date of Birth_____

Primary Physician _____ Endoscopy Physician _____

Allergies:_____

Reactions to allergies include:

_____

| Medication | Reason for taking | Dosage | How many times per day | Date last taken |
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Nurse Signature _____ Date _____

Physician Signature _____ Date _____