Hillside Gastroenterology & Nutrition, Inc.
Hillside Endoscopy Center, LLC

Medication and Allergy Information
Please fill this form out completely prior to your appointment.

Patient Name:_____ **Date of Birth:**___/___/____

Allergies

Please include both Medication and Environmental allergies.
(If None please say NONE. If reaction unknown please write UNKNOWN.)

Allergy:	Reaction:	Allergy:	Reaction:

Medications

Please include Prescription, Over-the-counter and Vitamins/Suppliments.

Medication	Dose	How often do you take this? (Daily, Twice daily, Weekly, As needed, etc)	When do you take this? (Morning, Afternoon, Evening)	How do you take this? (By mouth, Nasal, Eye drops, Cream, etc)	Why do you take this? (Asthma, High blood pressure, Migraines, Diabetis, Pain, etc)