Cleveland Gastroenterology Associates, P.A.

Patient Name________________________________Acct#______________________DOB_________________

What pharmacy do you use?____

MEDICATION **DOSAGE / FREQUENCY** (Please list medication, strength and dosage below)	DATE of Visit ----------	DATE of Visit ---------	DATE of Visit ---------	DATE of Visit ---------
I hereby certify that the above information I have provided is true and accurate to the best of my knowledge.	Patient Initials _________	Patient Initials _________	Patient Initials _________	Patient Initials _________

MEDICATION ALLERGY	REACTION	MEDICATION ALLERGY	REACTION