NACOGDOCHES
G.I. CONSULTANTS
PLLC

Patient Name: _____ Date of Birth: _____

MY MEDICATIONS

My list of Medications*	Times/Day	Strength (mg)

My list of Non-Prescription Drugs*	Times/Day	Strength (mg)

(If additional space is needed to list all medications, please continue on next page)

Known Allergies

_____

_____

_____

MY TREATMENT TEAM

	Name	Phone
Primary Care Physician		
Nurse/TCM		
Therapist		
Psychiatrist		
Other		
Other		

NACOGDOCHES
G.I. CONSULTANTS
PLLC

Patient Name: _____ Date of Birth: _____

MY MEDICATIONS (CONTINUED)

My list of Medications	Times/Day	Strength (mg)

My list of Non-Prescription Drugs	Times/Day	Strength (mg)