Norman Endoscopy Center

Medication/Allergy Reconciliation Record

Patient Label

Patient Preferred Pharmacy Name_____ Location_____

Source of Medication List (Check all that apply): ❑ Patient Interview ❑ Previous Medical Record, Dated_____

❑ Other_____ Interviewer:_____ Date:_____

Allergies/Sensitivities & Reactions (Include all drugs, materials, food, allergens, pets, mold and any environmental allergy) * INCLUDE THE SEVERITY OF THE REACTION			
❑ **NKA (No Known Allergies)**	Reaction	Name	Reaction
Egg/Soy Allergy ❑ yes ❑ no	Reaction	Name	Reaction
Latex Allergy ❑ yes ❑ no	Reaction	Name	Reaction
Name	Reaction	Name	Reaction
Name	Reaction	Name	Reaction

Medication History (Include prescription, herbal, and over-the-counter medications)

Date Last Taken	Medication Name	Dose/Frequency	Stop Before Procedure? Yes-date	Continue Medication after procedure? Yes-date
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:
				❑ no ❑ yes:

I have reviewed the Medication/Allergy list and verify that it is a complete list of my current medications and allergies.
I understand the purposes of my medications and how and when to take them ❑ yes ❑ no

Patient Signature_____ Date_____

( ) Medication History continues on page 2

New Prescriptions Added Post-Procedure		**❑ No New Medications**
Medication	Start Date	Comments

(this section for office use only)

Signature Review of Medications and Allergies across the Patient Care Continuum

Pre-op:_____ Intra-procedure:_____ Discharge:_____

Medications/Allergies/Medical History/Pre-procedure Nursing Assessment Reviewed:

Physician Signature:_____ CRNA Signature (if applicable):_____