Athens Gastroenterology Association, PC Jeff Williams, MD

Name:	Primary Doctor:	Phone:
Birth Date:	Other Doctors:	Phone:
Phone Number:	Primary Pharmacy:	Phone:

List All Allergies (Food or Medication)

Medication/Food	Describe Reaction	Medication/Food	Describe Reaction

Please list all prescription medications, over-the-counter medications, herbal supplements, and/or vitamins you take:

Medication Name	**Dosage (ex: mg, units)**	**How to Take (ex: Take 1 Pill Daily)**	**When do you take this medication?**					**Why are you taking this medication? (ex: High Blood Pressure)**
			Morning	**Noon**	**Dinner**	**Bedtime**	**As Needed**	