



PATIENT MEDICATION LIST

For your safety, the following must be completed prior to each appointment.

Patient Name:

Please circle all/any of the following **prescription** and **over the counter medications** you are presently taking as they may affect your *blood's ability to clot*:

- | | |
|-----------------------|----------------------|
| Aggrenox [®] | Lovenox [®] |
| Aspirin | Motrin [®] |
| Coumadin [®] | Plavix [®] |
| Excedrin [®] | Pradaxa [®] |
| Heparin [®] | Vioxx |
| Ibuprofen | |

Please list any **pain medicines** or **routine medicines** you are taking:

Medicine Name	Dose	# Per Day
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Others, please list:
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Please list all/any **drug allergies**:

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