



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 | |

Others, please list:

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

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

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