Patient Medication Form

Date: _____

Name _____ Birthdate: _____

Are you ALLERGIC to any medications?

☐ **No**, I have no known allergies to medication.

☐ **Yes**, I have an allergy to the medication(s) listed below:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Do you take any of the following BLOOD THINNERS? (Please mark all that apply).

☐	Aspirin		☐	Plavix	(Clopidogrel)
☐	Coumadin	(Warfarin)	☐	Pradaxa	(Dabigatran)
☐	Aggrenox	(Dipyridamole)	☐	Lovenox	(Enoxaparin)
☐	Xarelto	(Riveroxaban)	☐	Ticlid	(Ticlopidine)
☐	Effient	(Prasurgrel)	☐	Fragmin	(Dalteparin)

Do you have a PACEMAKER? ☐ Yes ☐ No

Do you have a DEFIBRILLATOR? ☐ Yes ☐ No

Please list all medications that you are currently taking.

Prescribed Medication	Dosage	Over the Counter Medication - INCLUDING vitamins and supplements	Dosage