PARADIGM HEALTH SYSTEM
A NEW DIRECTION IN HEALTHCARE

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®
Aspirin
Coumadin®
Excedrin®
Heparin®
Ibuprofen
Lovenox®
Motrin®
Plavix®
Pradaxa®
Vioxx

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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