Medication and Allergy Questionnaire

Do you take aspirin DAILY?	☐ No	☐ Yes
Do you take Plavix (clopidogrel)?	☐ No	☐ Yes
Do you take Coumadin (warfarin)?	☐ No	☐ Yes
Do you any other blood thinners?	☐ No	☐ Yes
Do you take arthritis medication?	☐ No	☐ Yes
Do you take acid reflux/heartburn medications?	☐ No	☐ Yes

Please list all medications taken / dose / frequency:

Medication Name	Dose (mg)	Frequency (1/day, 3/day, etc.)

Preferred Pharmacy: _____

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list medication AND reaction (<u>required</u>) _____

Are you allergic to latex? ☐ No ☐ Yes

Are you allergic to iodine? ☐ No ☐ Yes

_____

Patient Signature Patient Name (printed) Date