CATALYST Medical Group | Lewiston Orthopaedics

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# Medication Form

Patient Name _____Date_____Pharmacy of Choice_____

Are you currently on any type of blood thinner: ___ Yes ___No

If yes, what are you taking? ___Aspirin ___Pradaxa ___Coumadin/Warfarin ___Lovenox ___Plavix ___Other

Please list ALL medications including over-the-counter medications, herbs, and/or vitamins.

| Name of Medication | Dose | How Often Taken | Reason for Taking |
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Do you have any allergies or adverse reactions to drugs? ___Yes ___No

| Allergies and drugs to avoid/adverse reactions (Please list): |
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