METHODIST UROLOGY, LLC

MEDICATION LIST

PATIENT NAME ____ DATE OF BIRTH ____________________

ALLERGIES

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ARE YOU TAKING ANY BLOOD THINNERS OR ANTICOAGULANTS? IF YES, WHAT ARE THEY?

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DO YOU TAKE ANY VITAMINS, CALCIUM, OR OTHER DIETARY SUPPLEMENTS? IF YES, WHAT ARE THEY?

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DATE STARTED	PLEASE LIST CURRENT MEDICATIONS (include over-the-counter drugs)	DOSAGE	FREQUENCY	NOTES