IU HEALTH PHYSICIANS

MEDICATION LIST

PATIENT NAME ______________________________ DATE OF BIRTH ______________

ALLERGIES ____

____

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? ____

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