Medication List

Please list all current medications:

NAME OF MEDICATION	DOSE	HOW OFTEN	REASON FOR TAKING MEDICATION

If you have any of these problems, Please check all that apply:

( )ankle swelling
( )calf cramping
( )cardiovascular problems or chest symptoms
( )chest pain or pressure
( ) tightness in chest
( ) varicosities
( ) weight changes
( ) leg swelling
( ) non-healing wound
( ) breathing difficulties or respiratory symptoms
( ) dyspnea on exertion
( ) fatigue
( ) pacemaker
( ) shortness of breath
( ) addiction
( ) headache, nausea, dizziness
( ) calf pain
( ) gout attack
( ) numbness
( ) weakness
( ) fever
( ) cough
( ) GI symptoms
( ) GU symptoms
( ) bleeding problems
( ) blood clotting problem
( ) excessive scar tissue
( ) joint swelling
( ) flu-like symptoms

I verify that these are all the medications that I am taking at this moment. If at anytime they change I will call or let the office know that changes have been made to my medication list.

Signature: _____ **Date**:_____