CARY GASTROENTEROLOGY ASSOCIATES

Patients Name:_____ DOB:_____

Medications: Please list names of medications, dose, strength,and how often you take it
Please include any supplements, herbs, and vitamins.

Important: Do you take any of the following blood thinners? Circle and list below.
Aspirin, BC or Goodies, Aleve, Motrin, Ibuprofen, Naprosyn, Coumadin, Warfarin, Vit E, Plavix, Lovenox, Ticlid, St. John's Wort, and any other herbs/supplements.

O I TAKE NO medications or supplements/herbs/vitamins regularly

Medications	Dose / Strength	# of times day