ESPINOZA
VEIN INSTITUTE
HEALTHY LEGS, A STEP AWAY

NEW PATIENT – MEDICATION LIST

Patient: Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Gender: M /F

Are you currently taking any medications? [ ] Yes [ ] No

If yes, please print and list your medications below **OR** prepare a complete list, with the stated information below, **and present it to a member of our staff at the time of check in.**

1. Drug: _____ Dose: _____ Frequency: _____
2. Drug:_____ Dose: _____ Frequency: _____
3. Drug:_____ Dose: _____ Frequency: _____
4. Drug:_____ Dose:_____ Frequency: _____
5. Drug: _____ Dose: _____ Frequency: _____
6. Drug:_____ Dose: _____ Frequency: _____
7. Drug:_____ Dose: _____ Frequency: _____
8. Drug: _____ Dose: _____ Frequency: _____
9. Drug:_____ Dose: _____ Frequency: _____
10. Drug:_____ Dose: _____ Frequency: _____

CONSENT AND SIGNATURE

By signing below, I acknowledge that the information provided is accurate to the best of my knowledge. I understand that this information will be used for diagnostic and treatment purposes.

Patient signature: _____ Date: _____