Hemophilia Center
OF WESTERN NEW YORK

936 DELAWARE AVENUE SUITE 300
BUFFALO, NEW YORK 14209

MEDICATION & INTERFERING SUBSTANCES QUESTIONNAIRE
HEMOSTASIS THROMBOSIS LAB OF WNY

PATIENT NAME:_____ **DATE:**_____

Some Blood tests for bleeding & clotting can be affected by a variety of over the counter & prescription medications, as well as dietary supplements & some vitamins. In order to provide your physician with the best results interpretation, please answer the following questions.

WITHIN THE LAST WEEK HAVE YOU TAKEN:

Ibuprofen_____ **Aspirin** _____ **Fish Oil** _____ **Vitamin E** _____

Aleve _____ **Motrin** _____ **Pepto Bismol** _____ **Midol** _____

Please list ALL other prescription medications, Over the Counter medications, Vitamins & Supplements, that you currently take or have taken in the past week & when you last took them.

Medication Name	Dose	# of Tabs/Caps	How many times/day	Time of Last Dose
Ex. Amoxicillin	250 mg	1 cap	2 x/day	8 am
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				