KOCHAN PAIN TREATMENT CENTER
Andrew Kochan, M.D. | Diplomate, Board of Physical Medicine

PATIENT MEDICATIONS / SUPPLEMENTS

Name _____ Date _____

DOB _____Date Updated _____Patient's Initials_____

MEDICATION / SUPPLEMENT NAME*	**DOSE**	**FREQUENCY**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

** Include any non-prescription drugs, vitamins, aspirin, etc. Please continue medication list on the other side if necessary.*

BLOOD THINNERS:

Are you on any blood thinner medications such as aspirin, Coumadin, Plavix, or others? **YES** [ ] **NO** [ ]

If yes, please list:_____

MEDICATION SENSITIVITIES: NONE [ ]	**REACTION**
1. _____	_____
2. _____	_____

MEDICATION ALLERGIES: NONE [ ]	**REACTION**
1. _____	_____
2. _____	_____

FOOD ALLERGIES OR SENSITIVITIES: NONE [ ]	**REACTION**
1. _____	_____
2. _____	_____

OTHER ALLERGIES: Are you allergic to or have you had a reaction to the following.

Steroids [ ] Contrast Dye [ ] Shellfish [ ] Morphine [ ] Fentanyl [ ] Aspirin [ ] DMSO [ ] Novocaine [ ] Lidocaine [ ] Valium [ ] Codeine [ ] Sulfa Drugs [ ] Penicillin [ ]

Other:_____ What type of reaction _____

COMORBIDITIES: Additional Disease / Conditions

Diabetes [ ] High Blood Pressure [ ] Cardiac Risk [ ] Stroke [ ] DVT [ ] Thyroid [ ]

Other:_____

_____ _____

Patient Signature Date

4835 Van Nuys Blvd, Suite 100, Sherman Oaks, CA 91403 | 818.995.9331 tel | 818.995.9334 fax
KochanCenter.com

KOCHAN PAIN TREATMENT CENTER
Andrew Kochan, M.D. | Diplomate, Board of Physical Medicine

PATIENT MEDICATIONS / SUPPLEMENTS (continued)

Name _____ Date _____

*MEDICATION / SUPPLEMENT NAME	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

_____ _____
Patient Signature Date

4835 Van Nuys Blvd, Suite 100, Sherman Oaks, CA 91403 | 818.995.9331 tel | 818.995.9334 fax
KochanCenter.com