

Coumadin (Warfarin) Lab Vist

Patient Name: _____ DOB: _____

Doctor: _____

What strength (milligrams) is your Coumadin (Warfarin) tablet? _____

What dose of Coumadin (Warfarin) are you currently taking? _____

Have you experienced any of the following since your last visit?

1. Any signs of bleeding? Yes No
(nose bleeds, gum bleeds, unusual bruising, blood in your urine or stool, orange/brown
Discolored urine, dark/tarry stools)
If yes then explain: _____

2. Any changes in your medications? Yes No
(includes prescriptions, over-the-counter, or herbal dietary supplement, new
medications, discontinued medications, changes in doses)
If yes then please explain: _____

3. Any changes in your diet? Yes No
(particularly green vegetables) If yes, how and by how much: _____

4. Do you smoke or drink alcohol? Yes No
If so, has the amount changed since your last visit? Yes No

5. How many doses of your Coumadin (Warfarin) have you missed since your last
visit? _____

6. Are there any other problems or concerns you have related to your Coumadin
(Warfarin) therapy? Yes No
If yes, please explain: _____

For Office Use Only:

Date: _____ PT: _____ INR: _____

Taken by: _____ Reported to: _____

Instructions Given to Patient:

- Continue same dose
- Increase dose to _____
- Decrease dose to _____
- Hold _____ dose(s) and resume current dose
- Hold _____ dose(s) and decrease dose to _____
- Other: _____