BlueStem Cardiology

Patient Name_____Birthdate_____Date_____

Doctor_____

Current Medications

Please list all your medications you are currently taking, the dose and frequency. Include Over the Counter medications, Eye Drops and Vitamins.
PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Medications	Milligrams

Drug allergies or intolerance? Please list.

What pharmacy do you use including local and mail order?

OUT OF MEDICATION? Please call your pharmacy for renewals.