MICHIGAN HEART GROUP

MICHIGAN HEART RHYTHM GROUP

WESTERN WAYNE HEART GROUP

New Patient Medication Information

Patient Name: _____ Date: _____

Patient Date of Birth: _____

Home Phone: _____ Work Phone: _____

Pharmacy Phone: _____

To assist the physicians and practitioners with your future medical evaluations, please list all current medications that you are taking. Include the name of the medication, the dosage, how many pills you take and how many times per day you take it, and whether your medications are called in to a local pharmacy for refills or obtained by mail order. Thank you for your assistance.

MEDICATION NAME	DOSAGE (mg)	HOW OFTEN TAKEN	TYPE OF ORDER (circle one)	COMMENTS
			local pharmacy / mail order	
ex. Norvasc	10 mg	1 tablet, three times a day	local pharmacy / mail order	
1			local pharmacy / mail order	
2			local pharmacy / mail order	
3			local pharmacy / mail order	
4			local pharmacy / mail order	
5			local pharmacy / mail order	
6			local pharmacy / mail order	
7			local pharmacy / mail order	
8			local pharmacy / mail order	
9			local pharmacy / mail order	
10			local pharmacy / mail order	
11			local pharmacy / mail order	
12			local pharmacy / mail order	
13			local pharmacy / mail order	

Please list any medication allergies_____