MID AMERICA
HEART & LUNG SURGEONS

# *PATIENT MEDICATION LIST*

**Date of visit:** _____

**Patient's Name:**_____ **Date of Birth:**_____ **Age:**_____

**Referring Doctor:**_____ **Family Doctor:**_____

**Current Medications:**

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Medication Name:**_____ **Dose:**_____

**Please list all medication allergies:** _____

**Latex Allergy?** ☐ Yes ☐ No

**Iodine Allergy?** ☐ Yes ☐ No

**HT:**_____

**WT:**_____

**BP:**_____

**HR:** _____

**RR:** _____

**O2:**_____

**Temp:** _____