'Ohana CARDIOLOGY

CURRENT MEDICATION LIST

Please provide a list at each office visit to our staff.

	MEDICATION NAME	DOSAGE (MG)	# TIMES PER DAY TAKEN	START DATE	PRESCRIBING PHYSICIAN
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Please list any allergies/intolerance to medications and reaction(s):

_____

_____

_____

Please list any other Allergies and reaction(s); *food, adhesive tape, x-ray contrast dye, latex etc.*

_____

_____

_____

I [_____], understand Dr. Michael Barry DO., FACC and Medical Providers of 'Ohana Cardiology rely on medication information I provide to them for my care, and any medication misinformation can result in hospitalization and/or death. By signing, I confirm the medication information I am providing here is accurate and complete.

PATIENT SIGNATURE: *please sign* _____ **DOB:** _____ **DATE:** _____