



# heartrhythm solutions

## MY MEDICATION LIST

Patient Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

***A Current Medication List Helps Prevent Errors.***

RX Date	Medication Name & Strength To include over the counter meds such as vitamins, herbs, diet supplements	Dosage (mg, ml, etc)	How & When to Use (Daily, at bedtime, etc)	Stop Date

Allergies:

