LEXINGTON HEART SPECIALISTS MEDICATION LIST

PATIENT NAME: **DOB:** **APPT DATE:**

DRUG ALLERGIES: _____

_____

NAME OF MEDICATION	MG	DOSAGE
Example: Plavix	75 MG	1 a day

Name of your Pharmacy:_____ **Phone #:**_____

Do you have a pacemaker? Yes or No **Are you Diabetic? Yes or No**