Cardiology Consultants of Houston, PLLC **Medication History**

Name:	DOB:
Doctor:	Date:

List ALL Prescription and Non-Prescription Medications/Supplements

Name of Medication	Dose/Strength	How often taken?	Comments
		❍ daily ❍ 2x day ❍ 3x day ❍ 4x day ❍ as needed	
		❍ daily ❍ 2x day ❍ 3x day ❍ 4x day ❍ as needed	
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Pharmacy Info	
	Name:
	Location:
	Phone Number:

Prescription Plan	
	Name:
	Subscriber:
	DOB:
	Policy ID:
	Customer Service Number:

Allergies/Intolerances

Signature of Patient **Date**

Reviewed by **Date**