PATIENT MEDICATION RECORD

Your Name:	
Your Clinic Number:	
Your Medications:	**Times You Take This Medication:**
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	

Please complete this information and send to the Center for Atrial Fibrillation via fax to 216.445.6160 TWO WEEKS before your scheduled procedure.

Your Medications:	**Times You Take This Medication:**
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	
Type:________ Name:________ Dose:________	

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