

Patient Name: _____ Date: _____

Please provide a list of all of your current medications including prescriptions, over the counter, vitamins, or herbal supplements.

Medication Name:	Strength:	How many times a day:
Example: Nexium	40mg	One tablet every morning
_____	_____	_____
_____	_____	_____
_____	_____	_____
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Allergies: _____