Medications List

Please include a complete list of all medications taken, including prescription and “over the counter”

Patient Name:_____ Date: _____

Medication Name	Dose	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____