

Please list current medications: (include over the counter, vitamins and supplements)

	Name of Medication	Dose	Directions
1.			
2.			
3.			
4.			
5.			
6.			
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9.			
10.			
11.			
12.			
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14.			
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16.			
17.			
18.			
19.			
20.			

Please list all medication allergies:

Please attach separate sheet if additional space is needed