MEDICATION LIST

Patient Name ________________________________ DOB __________

Name of medicine and strength	How do you take the medication	Prescribing doctor’s name	Doctor’s phone number
200 mg/capsule (example)	*2 capsules every 4-6 hours*	*John Smith*	*(704) 555-0199*

Please include prescription and over the counter medications on this list.

Allergies and Reactions ____

Patient/Guardian, Relationship to Patient _____________________________ /__________

Signature ______________________________ Date __________

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