Patient Name *(print)*:_____ DOB:_____

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What Medications and Supplements Do You Take?

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.
Update this every time you visit.

Prescriptions						
Name of medicine	Dose Total milligrams	# / Day		Who prescribed it for you? Last name	Why is it taken?	Side effects? Describe
Over-the-counter medications, herbal remedies, vitamins						

_____
Patient Name (Please print)

_____ _____
Patient Signature Date