**Medication Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­\_\_\_\_\_\_\_\_\_\_\_\_ Patient # \_\_\_\_\_\_\_\_\_\_

Office Use

List all medications you are currently taking. Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye-drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

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| **Medication/ Drug Name** | **Dose** | **Frequency** |
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Please list any known allergies:

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