Patient Name:______________________________________**DOB:**_________________**Date:**__________________

Pharmacy Information:____

Medication List

PLEASE LIST ALL MEDICATIONS YOU TAKE and ANY KNOWN DRUG ALLERGIES by TYPING or SELECTING YOUR ANSWER. THEN PRINT and BRING TO OUR OFFICE.

I am currently on NO medications.

Medication Name	Strength	Dosage

I have NO known drug allergies.

I HAVE THE FOLLOWING DRUG ALLERGIES:

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