1.Must be completed for each visit
2.List medication that is prescribed by your primary care provider and specialists
3.List all over-the-counter medications and non-oral medications (e.g. inhalers, eye drops, creams or patches)
4.List oral contraceptives or hormone replacement therapy, or other products taken regularly such as herbal medicines or dietary supplements.

MEDICATION LIST

MEDICATION	DOSAGE	# OF TABS	TIMES PER DAY	PROVIDER
(example) Motrin	*800 mg tablets*	*1*	*twice daily*	

Name: LAST, FIRST
DOS: 01-30-2020

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