**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Medication list**

**Do you have any drug allergies?: No / Yes (If yes, please list and specify reaction, ie: hives, rash, itching, asthma, shock, etc.)**

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**Please list all prescription, Over-the-Counter, and supplements taken in the past 6 months:**

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| **Medication Name** | **Dosage/Route**  **Frequency** | **Reason for use** | **Last taken** |
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MD reviewed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse Reviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_