MEDICATION LIST

Patient Name: Healthcare Provider:

Allergies: Date completed:

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| **MEDICATIONS**  **Generic/Brand** | **REASON FOR USE** | **DOSE** | **HOW OFTEN I TAKE IT** | **M O R N I N G** | **N O O N** | **E V E N I N G** | **B E D T I M E** | **Special Notes/Instructions**  **\***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications. |
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| **OVER-THE-COUNTER/ HERBALS**  **Generic/Brand** | **REASON FOR USE** | **DOSE** | **HOW OFTEN I TAKE IT** | **M O R N I N G** | **N O O N** | **E V E N I N G** | **B E D T I M E** | **Special Notes/Instructions**  **\***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications. |
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