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| --- | --- | --- | --- |
| **Patient Name** |  | **Appointment Date** |  |
| **Patient Date of Birth** |  | **Gender** |  |

**Medications**

Please list below all drugs and medications taken over the last week

(including birth control pills, aspirin and any kinds of over-the-counter drug or medication of any kind)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Drug or Medicine** | **Dosage If Known** | **How Many Per Day** | **How Helpful is it?**  **(a lot) (some) (none)** | **Any Side Effects?**  **(yes) (no)** | **If Yes what is it?**  **(GI) (Skin) (Other)** |
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**Pharmacy Information**

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| --- | --- | --- | --- | --- | --- |
| **Pharmacy Name** |  | **Phone #** |  | **Address** |  |
| **Pharmacy Name** |  | **Phone #** |  | **Address** |  |
| **Signature** |  | | | **Date** |  |