MEDICATION LIST

PATIENT NAME ____________________ BIRTHDATE ____/____/____ PATIENT # ____________

ALLERGIES - DRUG REACTIONS

PHONE # ____________

PHARMACY ____________

PHONE # ____________

PROBLEM(S)	MEDICATION/STRENGTH	DIRECTIONS	NUMBER REFILLS	NURSE TO REFILL	DATE	REFILLS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
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				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					