Department: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Pharmacy ______________________

Page ______ of ______

Date of Visit: ______________________________

Food or Drug Allergies (note reaction): ______________________________

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____

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Latex Sensitivity? ☐ Yes ☐ No

CURRENT MEDICATION LIST

(List all current medications – both prescription and over the counter.
Include any vitamins, herbs, nutritional supplements, or recreational drugs that you routinely use.)

MEDICATION	DOSE	HOW OFTEN
EXAMPLE: *Frosty*	*10 mg*	*every morning*

Reviewed By: ______________________________ Date Reviewed ______________________

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