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Patient Name (please print) Patient DOB

Physician Pharmacy Pharmacy Number

Allergies:

Currently Taking: ­

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| **Date** | **Medication/ OTC** | **Dosage** | **Schedule/ Route** | **Quantity** | **Date Discontinued** | **Additional Testing/ Appointment Required** | **Nurse or Appropriate Designated Office Staff Signature/Physician or Applicable Provider Signature** |
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