MEDICATION LIST

Name:	Date:
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<u>Please list ALL medications</u> (including prescription, over-the-counter, herbal supplements, and vitamin/mineral/dietary supplements). Include the drug name, dosage, frequency, and route.

Drug Name	Dosage	Frequency	Route (circle one)
			ORAL INJECTION DROP
			TOPICAL Other
			ORAL INJECTION DROP
			TOPICAL Other
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