**PRESCRIPTION & SUPPLEMENT LIST**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please list your ACTIVE medications and supplements (not past medications).*

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| **Medication Name** | **Strength**  (i.e. 10mg) | **Dose**  (i.e. 2 tablets) | **Frequency**  (i.e. 2x/day or every # hours) | **How Taken**  (i.e. oral, topical) | **Date Started** |
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**DRUG ALLERGY LIST**

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| **Medication** | **Onset Date** | **Reaction**  (i.e. rash, vomiting, difficulty breathing,dizziness) |
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