| Patient Name | | | Date of Birth | | Date | |
|-------------------------|---------------------------|------------------|-------------------------|-----------------------|------------------------|-------|
| Pharmacy | | | | | | |
| Name | | Address | | | Phone | |
| Please list all pres | cription and over the | e counter medi | cations, herbal sup | plements and vi | itamins you are taking | g. |
| Name | | Dose | | When started/Why | | |
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| is my responsibility to | inform this office of any | changes in my me | dication, whether it be | e prescription or ove | r the counter. | |
| Signature | | | | Date | | |
| ****** | ******* | ********OFF | ICE USE ONLY*** | ****** | ******* | ***** |
| Medical History U | pdate | | | | | |
| Date/Initial | Changes | | | | | |
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