#  MEDICATION LIST

**Patient Name: Healthcare Provider:**

**Allergies: Date completed:**

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| **MEDICATIONS****Generic/Brand** | **REASON FOR USE** | **DOSE** | **HOW OFTEN I TAKE IT** | **MORNING** | **NOON** | **EVENING** | **BEDT IME** | **Special Notes/Instructions****\***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications. |
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| **OVER-THE-COUNTER/****HERBALS****Generic/Brand** | **REASON FOR USE** | **DOSE** | **HOW OFTEN I TAKE IT** | **MORNING** | **NOON** | **EVENING** | **BEDT IME** | **Special Notes/Instructions****\***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications. |
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