

Current medication and medication history

for: _____

Known medication allergies: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Brand name	Generic name	Dose (how much)	Route (how given)	Frequency (how often)	Date Started	Date stopped
					___/___/___	___/___/___

Reason (why given)	Who prescribed	Where purchased (pharmacy, specialty pharmacy, home service)	Comments

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