DIAGNOSTIC CENTER

LIST OF PATIENT'S MEDICATIONS

Dear Patient: Please complete this form listing all medications and bring this with you when you see the doctor.

Name:____

LIST ALL KNOWN ALLERGIES:

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LIST ALL PRESCRIPTIONS TAKEN:

Date Filled	Medication Name/Strength	Directions/How Taken

LIST ALL OVER THE COUNTER MEDICATIONS AND HERBAL MEDICATIONS TAKEN:

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PLEASE BRING ALL MEDICATIONS WITH YOU AND THIS COMPLETED FORM WHEN YOU SEE THE DOCTOR.