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| **PATIENT MEDICATION RECORD** |
|  |  |  |  |  |  |
| Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
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| Pharmacy & phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |  |  |  |
| **Date** | **Medication Name/Strength(including over-the-counter)** | **Dose** | **Direction** | **Reason for Taking** | **Provider Name** |
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