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| **PATIENT MEDICATION RECORD** | | | | | |
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| 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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