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CURRENT LIST OF MEDICATIONS

Please complete to the best of your ability

Medication Name of Medication Or what you take it for	**Dosage** Specific Amount	**Frequency** How Often	**Route** Injection Topical Oral Inhalation	**Last Taken** Date & Time Medication last taken

SIGNATURE: _____ **DATE**: _____
Person responsible for bill (Patient/Spouse/Guardian/POA)