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Current date: _____

Name: _____ Date of birth: _____

Please be sure to include any and all of the following:

- * Prescriptions
- * Over-the-Counter medicines
- * Herbal Supplements
- * Vitamins and Minerals
- * Dietary Supplements

If you need additional space, please include the information below on the back of this page.

Medication	Dosage	Frequency	Route of Administration