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*Family Practice*

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Patient name \_\_\_\_\_ Date \_\_\_\_\_

Email address \_\_\_\_\_

## Medications (include vitamins & supplements)

**Medication Name**

**Strength**

**Daily Dose**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Allergies (include meds & foods)

\_\_\_\_\_