

## Highland Primary Care

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## **Medication List**

Name:		DOB:	
complete list of all of prescribed medication remedies/supplement	your medications was, pain medications, and also medica	tient care, Highland Primar vith diagnosis. This should i is, over-the-counter medica itions you may take on occ have reviewed the informa	nclude daily ations, herbal asion. We will not
Patient's Signature:		Date:	
Medication	Dose	Frequency	Diagnosis

<sup>\*\*\*</sup> If additional room is needed, use the back of this sheet. \*\*\*