Neurology Medical Group of Diablo Valley, Inc

Patient Medication List

Patient Name: _____ D.O.B: _____Date:_____

Local Pharmacy:

Name: _____

Phone: _____Fax:_____

Address: _____

City:_____ State:_____

Mail Order/Other Pharmacy:

Name: _____

Phone: _____Fax: _____

Address:_____

City:_____State_____

1. Are you taking over the counter medications, such as cold remedies, vitamins or pain medications? If so, please list dose.

2. Please list all of you current prescription medications, including the dose and the number of times each day you take them

Medication Name	Strength	Dosage	Prescriber

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