**** Please complete the following information and bring with you to your first consultation ****

Patient Name:	Date:/
Date of Birth:/	Pharmacy Name:
Pharmacy Location:	Pharmacy Name: Pharmacy Phone: ()
ALLERGIES : List medications and	what reactions you have (Ex: Penicillin – rash)
1.	4.
2.	5.
3.	6
CURRENT MEDICATIONS:	
Please list <u>ALL</u> medications <u>prescr</u>	ibed and/or over the counter with the dosage
EXAMPLE: Nexium 40	Omg Once a day
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