Date: _____

Cecelia H. Boardman, MD
Tyler C. Ford, MD
Tricia D. Beisch, WHNP-BC

Medication and Allergy List

Patient: _____ **DOB:** _____

Pharmacy: _____ **Phone:** _____

Allergies: _____

_____

Please list ALL current medications, including over-the-counter items

For your safety, you will be asked to review this form and make any changes at EVERY visit.

Date	Medication	Dosage	Frequency (ex: 2 x daily, at bedtime)

For office use only: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

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