# MEDICATION HSITORY

| Name | | DOB | | SSN |
|---|---|---|---|---|
| Date | Medication Name | Dose | Frequency/Times per Day AM/PM/Noon/Bed | Side Effects/Allergy |
| *Chronologically list all prescription medications and over the counter medications you have taken, the date you started, dosage, frequency, dosage changes, any side effects or allergies, and date you discontinue use of them.* | | | | |
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