My Medical Planner
Your Healthcare Portfolio

MY PRESCRIPTION MEDICATIONS

PATIENT NAME: _____ **Date:**_____

ALLERGIES:_____

Medication Name	MG	When To Take/ Amount To Take	Treatment For	Date /Name Of Prescribing Dr
				Date: *Dr.*

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MY "OVER THE COUNTER" MEDICATION LIST

PATIENT NAME:_____

Medication	MG	When To Take It/Amount To Take	Treatment For

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