

Over-the-Counter (NON-Prescription) Medication Form

Please fill in all blanks

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pages

1
Name of Medication _____ Strength _____ Dosage form _____
EXACTLY how do you take it? _____
Reason(s) for taking this medication _____
Do you take it every day? YES _____ NO _____ (*please explain why and how you take it*)

2
Name of Medication _____ Strength _____ Dosage form _____
EXACTLY how do you take it? _____
Reason(s) for taking this medication _____
Do you take it every day? YES _____ NO _____ (*please explain why and how you take it*)

3
Name of Medication _____ Strength _____ Dosage form _____
EXACTLY how do you take it? _____
Reason(s) for taking this medication _____
Do you take it every day? YES _____ NO _____ (*please explain why and how you take it*)

4
Name of Medication _____ Strength _____ Dosage form _____
EXACTLY how do you take it? _____
Reason(s) for taking this medication _____
Do you take it every day? YES _____ NO _____ (*please explain why and how you take it*)

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5

Name of Medication _____ Strength _____ Dosage form _____

EXACTLY how do you take it? _____

Reason(s) for taking this medication _____

Do you take it every day? YES _____ NO _____ (*please explain why and how you take it*)

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Name of Medication _____ Strength _____ Dosage form _____

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Name of Medication _____ Strength _____ Dosage form _____

EXACTLY how do you take it? _____

Reason(s) for taking this medication _____

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EXACTLY how do you take it? _____

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9

Name of Medication _____ Strength _____ Dosage form _____

EXACTLY how do you take it? _____

Reason(s) for taking this medication _____

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Name of Medication _____ Strength _____ Dosage form _____

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13
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17

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25

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