



3841 Piper Street Suite T300 Anchorage, AK 99508

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Patient Medication List

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

(Please list all known allergies, reactions and cause)

_____ No Known Drug Allergies (X or initials)

1.
2.
3.
4.
5.