ELK GROVE DERMATOLOGY, S.C.
EST 1986

MEDICATION LIST

PATIENT NAME: _____ **DATE:** ____/____/____

PRESCRIPTION (RX) & OVER THE COUNTER (OTC) MEDICATIONS	DOSAGE/ STRENGTH	INSTRUCTIONS FOR USE, METHOD OF USE & FREQUENCY

PHARMACY PHONE NUMBER: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

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