Rhonda Rand MD Inc
Allergy, Pharmacy, and Medication List

Patient Name: ____ (please print)
Last **First** **M.I.**

Allergies: (Please list all allergies) **If none:** ☐

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Please provide your Preferred Pharmacy: (so that we can e-prescribe your prescription)

Pharmacy Name: ____

Pharmacy Phone number: ____________________

Please List ALL Medications (including over the counter, vitamins, and supplements) **If none:** ☐
****All fields are required****

Name:____

Strength:____________________ **Frequency:**____________________

Name:____

Strength:____________________ **Frequency:**____________________

Name:____

Strength:____________________ **Frequency:**____________________

Name:____

Strength:____________________ **Frequency:**____________________

Name:____

Strength:____________________ **Frequency:**____________________

See Back Side

Name:____

Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

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Strength:________________________ **Frequency:**________________________

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Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

Name:____

Strength:________________________ **Frequency:**________________________

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Patient Signature **Date**