SURGICAL ASSOCIATES
of Cleveland, P.C.
General Surgery & Vein Treatment Center

Medication List

DATE: _____

PATIENT NAME _____

DATE OF BIRTH:_____

PHARMACY NAME & LOCATION: _____

ALLERGIES: Please circle: None Known or Add Allergies: _____

_____

MEDICATION NAME	DOSE (MG)	HOW OFTEN

Please circle: No Medications or Add Medicines Below:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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