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PATIENT MEDICATION FORM

You may complete this form online
Print & BRING TO YOUR APPOINTMENT

Name→ Last _____ First _____ M.I. _____

D.O.B. _____ /_____ /_____

I consent to Cobb Internal Medicine obtaining my medication history from other providers/pharmacies:

Patient/Guardian Signature _____ Date _____

PLEASE LIST ALL MEDICATIONS YOU'RE TAKING

Name of PRERSCRIPTION Medications	MG/ Dose	How Often Taken?

Do you have any Allergies? ____YES ____NO If yes, please list all allergies

Allergies	Symptoms