MEDICATION LIST EMMANUEL CHRISTIAN HEALTH CENTER

rev. 11/2015

PLEASE HELP US PROVIDE YOU THE BEST OF CARE BY TAKING TIME TO FILL IN YOUR CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICINES ON THIS LIST. USE A BLANK SHEET OF PAPER WITH YOUR NAME WRITTEN ON TOP IF MORE SPACE IS NEEDED. YOU MAY ALSO ATTACH YOUR OWN LIST IF YOU HAVE ONE ALREADY. THANK YOU VERY MUCH. IT IS OUR PLEASURE TO SERVE YOU.

Your Name _____ **Date of Birth** _____ **Check here if you take no medicines.** ____

Name of Medication with Strength Examples: lisinopril 10 mg levothyroxine 50 mcg triamcinolone cream .05%	Directions (How often do you take or apply this medicine?) Examples: 1 capsule a day, 2 tablets twice a day, 1 at bedtime, 1 in the morning and 2 at night, 2 puffs 3 times a day as needed	Quantity you get with each refill
		___ 30 day supply ___ 90 day supply Other amount:
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