PATIENT NAME: ______________________________

PHARMACY NAME: ______________________________

PHARMACY PHONE# ______________________________

MEDICATION FORM

MFX# ______________________________

Please fill out this form and RETURN IT with all the medications (including OTC meds) you take. Please list your Allergies and the reaction you have.

Medications with dosage	*How Often*	*Who Prescribed*	*Date Prescribed*

ALLERGY	*REACTION YOU HAVE TO IT*	*ALLERGY*	*REACTION YOU HAVE TO IT*

STERLING HEIGHTS
44650 Delco Blvd
Sterling Heights, MI 48313
(586)254-1770 **Fax: 586-254-3515**

Macomb
21932 23 Mile Rd,
Macomb, MI 48042
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