MEDICATION LIST

NAME: _____

Date: _____

Please list all current medications including; Prescriptions, Eye drops, OTC's, Herbals, Vitamins, Supplements, Prescription Creams or Ointments

Medication	Strength/Dose	How Many	How Often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
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28			
29			
30			

Local Pharmacy and Phone #: _____

Mail Order Pharmacy: _____

Dr. Robert Rabinowitz, DO

462 Lakehurst Road
Toms River, NJ 08755

732.341.5403
Fax: 732.505.0862