## MEDICATION LIST- PLEASE PRINT CLEARLY

| Patient Name: | Date: |
|---|---|

## DRUG ALLERGIES

| Medication | Dosage- mg, units, ect. | Instructions- 1 a day, 1 twice a day, ect. | Prescriber |
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## DIABETES PATIENT

| Name of Glucose Meter: | |
|---|---|
| Frequency of Testing: | |