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Urology and Urologic Surgery

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Master Medication List

Today's Date	Last Name	First Name, Middle Initial
Date of Birth	Age	☐ Male ☐ Female

Do you have **ALLERGIES** to any medications and/or foods? ☐ Yes ☐ No **If yes, please list:**

_____

_____

Urologic Diagnosis: _____

_____

Please list all medications you are currently taking:

Medication	Daily Dose and Frequency	Reason

Pharmacy Name: _____ Pharmacy Phone: (_____) _____

Pharmacy Address: _____