PULLMAN REGIONAL HOSPITAL

CENTERED ON EXCELLENCE

Home Medication and Allergy Information

Please list **all** medications you are currently taking. Please include any prescribed medications prenatal vitamins, any other supplement, and any over the counter medications. Please provide the name, dosage, frequency, and time of day the medication is usually taken.

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Preferred Pharmacy_____

Please list any food and/or medication to which you are allergic and the symptoms you experience when exposed.

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