YOUR HEALTH PHARMACY

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MEDICATION ORDERS

Patient Name: Date of Birth:
Address: City: State: Zip:
Phone: Email:
Diagnosis:
Allergies: ☐ NKDA (no known drug allergies) ☐ Aspirin/ NSAID's ☐ Cyclobenzaprine ☐ Lidocaine / Local Anesthetic
☐ Tramadol ☐ Opioid ☐ Gabapentin ☐ Penicillin ☐ Amitriptyline ☐ Other:

Current Medications	Amount/ Dosage	Rational

PRN Meds		

Physician Name:
Address: City: State: Zip:
Phone: Fax:
DEA: NPI: