CLEARCHOICE
HEARING AND BALANCE
Sharp. Clear. Precise.

MEDICATION LIST

Name:_____ **DOB:** _____

Medication/Supplement	**Dosage**	**Frequency** (times per day)	**Route** (oral, injection, inhalant)	OFFICE USE ONLY **Discontinued, Added**

(additional space provided on back)

OFFICE USE ONLY

Reviewed by: _____ Date:_____ Change: Y / N

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