**List all medications and supplements you take regularly**

| Medication | Dose | Frequency (how often) |
|---|---|---|
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**Please list all medication allergies and the reaction you have if you take them**

| Allergic To: | Reaction | Allergic To: | Reaction |
|---|---|---|---|
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**List all Surgeries and Hospitalization**

| Date | Where | For What |
|---|---|---|
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