

Middle Georgia Allergy and Asthma, LLC

Medication Information

Last Name:	First Name:		
DOB:		Today's Date:	
Please list all prescription medications, vitamins	edications (including all inhalers and nas , herbal supplements including the dose	sal sprays), over-the-counter and how often taken.	
Medication Name	<u>Dose</u>	<u>Frequency</u>	
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