David F. Young MD, PC
DERMATOLOGY

David F. Young MD, PC
Esther Carson, PA-C
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# MEDICATION LIST

Patient Name:_____DOB:_____

Preferred Pharmacy:_____

| Medication Name | Strength or Dosage | Frequency/Route | Reason for Medication |
|---|---|---|---|
| *Example: Lisinopril* | *10 mg* | *Twice a day / by mouth* | *Hypertension* |
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