David F. Young MD, PC
DERMATOLOGY

David F. Young MD, PC
Esther Carson, PA-C
Christa Cavanaugh, PA-C
Drew Lakey, PA-C

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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