



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
<i>Example: Lisinopril</i>	<i>10 mg</i>	<i>Twice a day / by mouth</i>	<i>Hypertension</i>