Dr. Mani Khoshnejad, M.D.

Current Medications

Patients Name: _____ Date of Birth: ____/____/____ Date: ____/____/_____

Please list of any medications take on a regular basis. Include any prescribed or over the counter medications. (i.e. ointments, supplements, topical gels, pain relievers, etc.)

☐ No Current Medications

Medication Name | Dose:	**Frequency:**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

By signing this form, I acknowledge that the information above will help my provider during the time of my visit to ensure an accurate treatment. I also agree I filled out the above form and that all information above is complete and true, to the best of my knowledge.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Legal Guardian Signature (If applicable) Date

MANI K MD PA
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