ADVANCED UROLOGY
OF SOUTH FLORIDA
DIVISION OF UROLOGY GROUP OF FLORIDA, LLC

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Master Medication List

Date: _____/ _____/ _____.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/ _____/ _____.

Do you have ALLERGIES to any medications and /or foods? ☐ Yes ☐ No

If yes please List: _____

_____

_____

Urologic Diagnosis: _____

_____

Please list all medications you are currently taking:

Medication	Daily Dose & Frequency	Reason

Pharmacy Name: _____ Pharmacy Phone: _____

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