



**Prescription medication**

| <b>Medication Name</b> | <b>Dose</b> | <b>Frequency</b> |
|------------------------|-------------|------------------|
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**Over-the-counter medications such as aspirin, ibuprofen, vitamins, or laxatives**

| <b>Medication Name</b> | <b>Dose</b> | <b>Frequency</b> |
|------------------------|-------------|------------------|
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**Allergies or adverse drug reactions?** Please list drug and type of reaction.

**Are you allergic to iodine or shellfish?** Yes \_\_\_\_ No \_\_\_\_