



# **ENCORE Research Group**

*ENCouraging COmmunity Research and Education*

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

## **Medication List**

Medication Name	Dose & Frequency	Route	Start Date	Stop Date	Ongoing	Indication
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
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					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Notes:**  
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