



VILLAGE INTERNAL MEDICINE
PRESCRIPTION LIST

NAME: _____ DOB: _____ DATE: _____

PHARMACY _____ PHARMACY PHONE NUMBER: _____

1. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

2. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

3. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

4. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

5. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

6. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____

7. MEDICATION: _____

DOSAGE: _____

DIRECTIONS: _____