Patient Name: _____

DOB:_____

TEXAS HEALTH CARE, P.L.L.C.
923 PENNSYLVANIA AVE.
FORT WORTH, TEXAS 76104

MEDICATION/HERB LIST

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

PHARMACY: _____

PHARMACY PHONE NUMBER: _____

Medication/Herb	Dosage	Frequency