

# ALLERGY AND ASTHMA ASSOCIATES, P.C.

Richard C. Loria, M.D.

Courtney J. Blair, M.D.

Penny Flores, F.N.P

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

## 30 DAY MEDICATION LOG

	Medication Taken Name & Dosage	Date/Time	Relief Obtained Yes/No	Symptoms if no relief
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
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12				
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25				
26				
27				
28				
29				
30				

I certify the above information is correct and the 30 day trial has been completed \_\_\_\_\_  
Patient (or parent) signature

I certify the above patient has provided our office with this medication log and it has been placed in the patients' medical record to be included in his/her progress notes.

\_\_\_\_\_  
Physician Signature

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