Drug Prescription

Patient Information:

- **Name:** [Patient Full Name]
- **Age:** [Patient Age]
- **Gender:** [Male/Female/Other]
- **Patient ID:** [Patient ID or Registration No.]
- **Date of Birth:** [Patient DOB]
- **Prescription Date:** [Date of Prescription]
- **Doctor:** [Doctor's Name & Specialty]

Doctor’s Information:

- **Doctor Name:** [Doctor's Full Name]
- **Registration Number:** [Doctor's Medical Registration Number]
- **Clinic/Hospital:** [Clinic or Hospital Name]
- **Contact:** [Doctor's Contact Information]

Prescription:

Drug Name	Dosage Form	Strength	Dosage Instructions	Duration	Additional Notes
Drug 1	[Tablet/Syrup]	[mg]	1 tablet every 8 hours	5 days	[Take after meals]
Drug 2	[Capsule/Injection]	[mg/mL]	2 capsules per day	7 days	[Take with water]
Drug 3	[Ointment/Cream]	[mg]	Apply to the affected area twice	10 days	[Avoid exposure to sunlight]
Drug 4	[Inhaler/Spray]	[mcg/dose]	1 puff every 6 hours	As needed	[Shake well before use]

Additional Instructions:

- **Dietary Restrictions:** [e.g., Avoid spicy foods, reduce salt intake, etc.]
- **Exercise/Physical Activity:** [e.g., Light exercise recommended]
- **Follow-Up Appointment:** [Date of the next appointment, if needed]
- **Warnings:** [e.g., Do not drive after taking medication, Avoid alcohol, etc.]

Doctor’s Signature: [Doctor's Signature]
Date: [Prescription Date]