

My Medicines

Doctor's Name

Phone Number

Pharmacy Name

Phone Number

Medical Conditions

Vaccination Record:

(Include dates administered)

- Tetanus _____
- Pneumonia Vaccine _____
- Flu Vaccine _____
- Other _____

- List all your medicines on this form
- Always keep this list with you
- Share this with your doctor, nurse, pharmacist and caregivers

Ask Questions – It's OK

- Why am I taking this medicine?
- How long do I take this medicine?
- Are there any side effects?
- Do I continue my other medicines?

Medicine Abbreviation Definitions

ac: *before meals*
bid: *twice a day*
hs: *at bedtime*
po: *swallow it*
prn: *as necessary*
q: *every*
qd: *every day*
qid: *four times a day*
sig: *write*
STAT: *immediately*

*Partners
in
Safety*

Copies of this form are available at:
www.AuroraHealthCare.org

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