My Medicines

Doctor's Name **Phone Number**

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Pharmacy Name **Phone Number**

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Medical Conditions

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Vaccination Record

(Include dates administered)

❑ Tetanus ______________________________

❑ Pneumonia Vaccine ____________________

❑ Flu Vaccine ___________________________

❑ Other _________________________________

- List all your medicines on this form.
- Always keep this list updated and carry it 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*
h: *hours*
hs: *at bedtime*
pc: *after meals*
po: *swallow it*
prn: *as necessary*
q: *every*
qd: *every day*
qid: *four times a day*
sq or Sub Q: *subcutaneous (under the skin)*
STAT: *immediately*
tid: *three times a day*

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Partners in Safety

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

www.AuroraHealthCare.org

My Name ______________________ Allergies ______________________

Date ______________________

Prescription Medicines

Name of medicine	Dose (Examples: mg, ml, units, puffs, drops)	When do I take this medicine? (check time)					Why do I take it?
		AM	Noon	PM	Bed - time	With Food	

Over-the-Counter Medicines (such as herbals, vitamins, antacids, aspirin)

Name of medicine	Dose (Examples: mg, ml, units, puffs, drops)	When do I take this medicine? (check time)					Why do I take it?
		AM	Noon	PM	Bed - time	With Food	