MY MEDICATIONS

SYRINGA HOSPITAL & CLINICS

Name: **DOB:** **Date:**

ALLERGIES:	My Doctor: Phone: My Pharmacy: Phone:

List all your medications on this form. Share this with your doctor, nurse, pharmacist and caregivers

PRESCRIPTION MEDICINES

Name of Medicine	**Dose** (mg, ml, units, puffs, drops)	**When do I take this medicine?**					**Why do I take it?**
		AM	Noon	PM	Bed Time	With Food	

Pneumonia vaccine date given:

OVER-THE COUNTER MEDICINES (herbals, vitamins, antacids, aspirin, etc).

Name of Medicine	**Dose** (mg, ml, units, puffs, drops)	**When do I take this medicine?**					**Why do I take it?**
		AM	Noon	PM	Bed Time	With Food	