

Medical Conditions

- 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?

My Medications

Vaccination Record:

(Include dates administered)

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

Doctor's Name _____

Phone Number _____

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

Pharmacy Name _____

Phone Number _____



St. Nicholas Hospital

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