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# Current Medication LIST

Name:

DOB:

Medicare:

Address:

Tel:

Name of medication <ul style="list-style-type: none"> <li>• mg per dose?</li> <li>• Reason for taking?</li> <li>• Year/date began taking it?</li> <li>• Side effects?</li> </ul>	Daily	Morning	Lunch	Afternoon	Evening
	Twice Daily Three times daily Weekly Monthly As needed				

Please update this list as it changes, and keep it with your scripts or paperwork when you need to see a doctor, specialist, ambulance or prior to surgery.