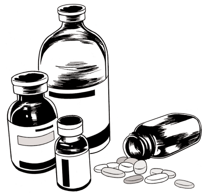
Medicines record - Tablets or liquids that do not make me feel better

Name	Side effects

Medicines record - Tablets or liquids that do not make me feel better

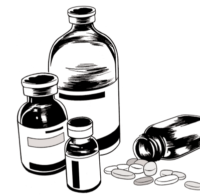
Name	Side effects



My medicines

(Please print)

Medication name and what it is for. State if blood test is needed	When I will take it	Date started & doctor signature	Date stopped & doctor signature



My medicines

(Please print)

Medication name and what it is for. State if blood test is needed	When I will take it	Date started & doctor signature	Date stopped & doctor signature

Update page

Date	What has changed	Name / job

Update page

Date	What has changed	Name / job