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| **My allergies & how I react:** | Click or tap here to enter text. |

**My Medicines**

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| **Name** | Click or tap here to enter text. | **Date of birth** | Click or tap here to enter text. | **Date I filled**  **out this form** | Click or tap to enter a date. |

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| --- | --- | --- | --- | --- | --- | --- |
| **Name of medicine or supplement** | **Strength** | **How much I take each time** | **I take it** | **I take it every day (Yes / No)** | **Why I take it?** | **My notes** |
| **Example:** ABC Tablets | 25mg | 2 tablets | Once in the morning | Yes | For my heart | Take with food |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
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