KNOW YOUR MEDICINES
ASK YOUR PHARMACIST

MALAYSIAN PHAMACEUTICAL SOCIETY

KNOW YOUR PHARMACIST

Pharmacist : _____

BIODATA

Name:_____

Date Of Birth:_____

Tel:_____

Illness/Medical History:

_____

Allergies(drug):_____

MEDICATION RECORD

No.	Medication	Strength	Color/ Shape	Indication	Dosage			Remarks
					am	pm	night	Before/After Food
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								