Australian Government
Department of Veterans' Affairs

Pharmaceutical Society of Australia

MediList and Health Record

- To complete this form place cursor in required field and commence typing. Alternatively, you may tab through each field to complete.
- Please ensure you SAVE this form before you PRINT the form. This will ensure that all data will be captured within the form.
- This form can be completed and saved on-screen using the latest version of Adobe Acrobat Reader. Get Adobe Acrobat Reader

VETERAN'S DETAILS

Full name

Address

Telephone (incl. area code)

Veteran's file number

Medicare number

Pensioner number

DVA card type ☐ Gold Card ☐ White Card ☐ Orange Card

DOCTOR'S DETAILS

Name

Telephone (incl. area code)

PHARMACIST'S DETAILS

Name

Telephone (incl. area code)

USING THIS MEDILIST

- Ask your pharmacist and doctor to fill in your MediList showing ALL the medicines you use regularly (including medicines prescribed by doctors and medicines bought from pharmacies, supermarkets or health food shops).
- Ask your doctor/dentist/pharmacist/nurse/carer/hospital to update your MediList whenever a new medicine is added or your medicine(s) change.

QUESTIONS FOR MY PHARMACIST

1. How and when is the best way to **use** this medicine?
2. What food, drink, activity or storage might affect how well this medicine works?
3. What can I do to reduce the chance of any **side effects**?
4. What should I do if side effects occur?
5. Please fill in/check this **MediList**. Will this medicine **interact** with other medicines I use?
6. What should I do if I **miss a dose**?
7. Can you give me any **information** about this medicine or my condition?
8. Using medicines is a problem because of my sight/swallowing/strength/memory. How can you **help** me?
9. When should I **stop** taking my medicines?

QUESTIONS FOR MY DOCTOR

1. What is my **health problem**?
2. How long is it likely to last?
3. What can I do to **help myself** get better?
4. What is the **name** of the new medicine(s) you have prescribed for me?
5. What does the medicine **do** and how should I **use** it?
6. How **long** should I use it?
7. Are any **side effects** likely or should I expect to feel any different while taking this medicine?
8. When should the medicine be **reviewed** or stopped?
9. Please fill in/check this **MediList**. Will this medicine **interact** with other medicines I use?

Please complete following pages

Full name

Veteran's file number

Date started (dd/mm/yyyy)	Name of Medicine Brand or generic name	Strength	What it's for	Dose/Timing B'fast	Lunch	Dinner	Bed	Special instructions / Comments

Please complete details on next page ⟶

Full name

Veteran's file number

Allergies

Test:	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result
Blood pressure						
Weight						

If appropriate:	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result
Urinalysis						
Blood cholesterol						
Blood sugar						
Prostate check						
Glaucoma						
Pap test						
Mammogram						

Other test:	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result	Test date (dd/mm/yyyy)	Result

Date for next: (dd/mm/yyyy)

Eye test

Dentist visit

Tetanus vaccination

Influenza vaccination

Pneumococcal vaccination

Other:

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SAVE FORM

PRINT FORM

CLEAR FORM