4. KEEP A RECORD OF MEDICINES YOU USE

NAME: _____

DOCTOR: _____ **PHONE NUMBER:** _____

List any allergies _____

_____

Check boxes for the ones you use:

- ☐ Aspirin or other pain/headache/ fever medicine
- ☐ Allergy medicine
- ☐ Antacids
- ☐ Cold medicine
- ☐ Cough medicine
- ☐ Diet pill/supplements
- ☐ Laxatives
- ☐ Sleeping pills
- ☐ Vitamins
- ☐ Minerals
- ☐ Herbals
- ☐ Others _____

_____

_____

DATE	NAME OF MY MEDICINE	HOW MUCH DO I TAKE	WHEN DO I TAKE IT	WHAT DO I USE IT FOR	REFILLS
EXAMPLE	XXXX	1 tablet 400 mg	3 times a day after meals	Arthritis	2

KEEP THIS IN YOUR PURSE OR POCKET AND SHOW IT TO YOUR DOCTOR, PHARMACIST, OR NURSE.

Have your doctor, pharmacist, or nurse report serious medication problems to the FDA at 1-800-FDA-1088.

Go to Drugs@FDA to find more information about your medicines