

MEDICATION TRACKER

The 12-Dose Regimen for Latent Tuberculosis (TB) Infection

Your Medication Schedule

(Providers: Indicate the appropriate number of pills and day)

Medicine	Number of pills per week	Frequency	Day
Isoniazid: ___ mg Rifapentine: ___ mg	TOTAL: _____ (Isoniazid: _____, Rifapentine: _____)	Once a week for 12 weeks (3 months)	M T W Th F S Sun

Your doctor may also add Vitamin B6 to your treatment plan.

Keeping Track of Your Treatment

On the table below, check the box and write the date to show when you took your medicine.

WEEK	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
EXAMPLE 5/7 - 5/13	<input type="checkbox"/> _____	<input checked="" type="checkbox"/> 5/8	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 1	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 2	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 3	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 4	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 5	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 6	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 7	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 8	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 9	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 10	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 11	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 12	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____



Centers for Disease Control and Prevention
National Center for HIV/AIDS,
Viral Hepatitis, STD, and
TB Prevention

www.cdc.gov/tb

CS292853B

SYMPTOM CHECKLIST

The 12-Dose Regimen for Latent Tuberculosis (TB) Infection

Patient Name: _____



Normal Side Effects

Most people can take their TB medicines without any problems. The rifapentine medicine may cause your urine (pee), saliva, tears, or sweat to appear an orange-red color. This is normal and the color may fade over time.



STOP taking your medicine and CALL your TB doctor or nurse right away if you have any of the problems below:

- | | |
|---|---|
| <input type="checkbox"/> Dizzy or lightheaded when sitting or standing | <input type="checkbox"/> Skin or whites of your eyes appear yellow |
| <input type="checkbox"/> Less appetite, or no appetite for food | <input type="checkbox"/> Skin rash or itching |
| <input type="checkbox"/> Stomach upset, nausea, or vomiting | <input type="checkbox"/> Bruises, or red or purple spots on your skin that you cannot explain |
| <input type="checkbox"/> Stomach pain or stomach cramps | <input type="checkbox"/> Nosebleeds, or bleeding from your gums or around your teeth |
| <input type="checkbox"/> Pain in your lower chest or heartburn | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Flu-like symptoms with or without fever | <input type="checkbox"/> Pain or tingling in your hands, arms, or legs |
| <input type="checkbox"/> Severe tiredness or weakness | <input type="checkbox"/> Feelings of sadness or depression |
| <input type="checkbox"/> Fevers or chills | |
| <input type="checkbox"/> Severe diarrhea or light colored stools (poop) | |
| <input type="checkbox"/> Brown, tea-colored, or cola-colored urine | |



Please talk to your doctor or nurse if you have any questions or concerns about treatment for latent TB infection.

Doctor/Clinic Contact Information

Name of the staff caring for you: _____

Phone number: _____

Address: _____

Hours: _____



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