

# My Medicine Record



Name (Last, First, Middle Initial): \_\_\_\_\_

Birth Date (mm/dd/yyyy): \_\_\_\_\_

	<b>What I'm Using</b> Rx – Brand & generic name; OTC – Name & active ingredients	<b>What It Looks Like</b> Color, shape, size, markings, etc.	<b>How Much</b>	<b>How to Use / When to Use</b>	<b>Start / Stop Dates</b>	<b>Why I'm Using / Notes</b>	<b>Who Told Me to Use / How to Contact</b>
<b>— Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements —</b>							
Ex:	XXXX/xxxxxxxxxx	20 mg pill; small, white, round	40 mg; use two 20 mg pills	Take orally, 2 times a day, at 8:00 am & 8:00 pm	1-15-11	Lowers blood pressure; check blood pressure once a week; blood test on 4-15-11	Dr. X (800) 555-1212
1							
2							
3							
4							
5							
6							
7							
8							

# My Medicine Record



## My Personal Contacts

My Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)
---------------------------------------	-------------------------

Contact Information

## Emergency Contact

Name	Relationship
------	--------------

Contact Information

## Primary Care Physician

Name

Contact Information

## Pharmacy / Drugstore

Name

Contact Information

## Allergic Reaction or Other Problem I've Had With...

**any medicine, dietary supplement, food, skin cleaner, medical tape**

Describe in space below.

## My Medical Conditions and Operations

Describe in space below.

## Questions I Should Ask About Medicines or Dietary Supplements

- ❖ **Fill in the record for any new medicine, prescription (Rx) or over-the-counter (OTC), or dietary supplement, or ask my doctor or pharmacist to help me fill it in. Make sure I can read what is written on the record.**
- ❖ **When I review the record, or a change is made, ask:**
  - Can I use a generic form?
  - When should I start to feel differently? When should I report back to the doctor?
  - Will this take the place of anything else I am using?
  - Are there any special directions for using this?
- Should I avoid any other medicines, dietary supplements, or treatments while using this?
- Should I avoid any drinks, foods, other substances, or activities while using this?
- What are the possible side effects from this? Is there anything I should watch for? What do I do if I get a side effect?
- Will I need any tests (blood tests, x-rays, other) to make sure it is working as it should? When? How will I get the results?
- What should I do if I miss a dose? What do I do if I use too much?
- Where and how can I get more written information about this?



## How to Use My Medicine Record

- **Use this record** with the “Be An Active Member of Your Health Care Team” pamphlet, found at:  
[www.fda.gov/Drugs/ResourcesForYou/UCM079529#pamphlet](http://www.fda.gov/Drugs/ResourcesForYou/UCM079529#pamphlet)
- **Save “My Medicine Record”** on your personal computer (PC). Type information into the fields with your keyboard. You can also print the record and enter the information with a pencil.
- **Enter ALL prescription medicines you use**, including any medicine samples you are given.
- **Enter ALL over-the-counter medicines and dietary supplements** (including vitamins, minerals, and herbals) you use, whether you use them all the time or only some of the time.
- **Print and share the record** with your doctors, pharmacists, or other health professionals at ALL your visits.
- **Keep a printed copy** with you all the time. It is a good idea to give a copy to a friend or loved one.

### Review this record and update it on your PC or by hand when you:

- Stop or start a medicine or dietary supplement
- Make a change in anything you use
- Visit your doctor, pharmacist, or other health professional

### What I’m Using

- **Prescription (Rx) medicine** – enter the brand and generic name of the medicine, including any samples you are given
- **Over-the-Counter (OTC) medicine** – enter the name and active ingredient(s), including OTCs you use for allergies, stomach ache, heartburn, nausea; OTC pain relievers you use for minor aches and pains, headache, fever; OTC cold medicines,

laxatives, sleeping pills, and others prescribed by your doctor, such as aspirin

- Dietary supplements, including vitamins, minerals, and herbals

### What it Looks Like

- Form (pill, tablet, capsule, liquid, injection, suppository, cream, lotion, eye or ear drops, etc.)
- Shape, color, size, and scoring (any lines on the medicine) or other markings

### How Much

- Dose that you are directed to use either by the doctor or pharmacist or by the directions on the label
- If you are to use a dose which is different than the dose the medicine comes in, note the number you use (for example, you are supposed to use 40 mg, and it comes in 20 mg pills, put “40 mg; use two 20 mg pills” or “2 pills”)

### How to Use / When to Use

- **How to use** – such as “swallow with water; do not chew” or “take by mouth with food” or “two times a day”)
- **When to use** – the time, or time of day, you use it (such as “10:00 pm” or “at bedtime”)

### Start / Stop Dates

- Date you started using it. If you are only supposed to use it for a period of time, put the date you should stop using it
- If it is something you use sometimes, such as an OTC you use only when you have a headache, put “when needed”



## How to Use My Medicine Record

### Why I'm Using / Notes

- The reason why you are using it, such as "high blood pressure"
- Any special directions on how to use the medicine, such as whether to take it with or without food
- Any tests that are needed to find out it is working as it should, and dates you need the tests
- How and where to keep or store it, if not at room temperature

### Who Told Me to Use / How to Contact

- Name and contact information of the doctor, nurse, or pharmacist (or other) who prescribed or told you to use it

### My Personal Contacts

- Contact information for you, someone you want contacted in an emergency, your doctor, pharmacy, or pharmacist. Under "Contact Information," enter phone number or e-mail address. An extra space is there for an extra contact person, if needed.

### Allergic Reaction or Other Problem I've Had With...

- Any medicine, dietary supplement, food, skin cleaner, medical tape with which you have had a problem

- Also enter anything that could have an effect on your use, such as pregnancy, breast feeding, trouble swallowing tablets, or trouble remembering to use. Include problems with ingredients, such as colors, flavors, starches, or sugars.

### My Medical Conditions and Operations

- Any diseases, illnesses, or medical conditions, such as asthma, diabetes, heart disease, high blood pressure, kidney disease, or cancer
- Any conditions or problems you often treat with prescription or over-the-counter medicine or dietary supplements, such as acid stomach or allergies
- Operations you've had

### Questions I Should Ask About Medicines or Dietary Supplements

- Fill in the record for any new medicine or dietary supplement, or ask your doctor or pharmacist to help you fill it in. Make sure you can read what is written. If you can't read it, others may have trouble reading it, too. Use these questions when you review the record with your health professionals or when a change is made in something you use.