Drug Worksheet for Patients, Family, Doctor and Pharmacist ©

Patient's Name _____ **Page** _____

Primary Doctor's Name _____ **Doctor's Telephone** _____

Generic Name of Drug / Brand Name of Drug	Doctor, date started & changes	Reason why prescribed or changed?	Dose? (Each time)	Times per day	What time of day?	How long should you take drug? days/weeks/ months	Problems to watch out for which this drug can cause	Interactions of this drug with other drugs or food; diet recommendations	How are you actually taking the drug?	New problems or complaints since drug started (date it began)	Is drug working?

Instructions:
1. Include all drugs you take including aspirin, herbs, vitamins and other nonprescription products as well as prescription drugs.
2. When you change doses draw a single line through the old dose.
3. Bring this with you every time you go to a doctor or pharmacist.
4. Be straightforward with your doctor and yourself about how often you take medicine and why.

See sample worksheet (filled-in), *Worst Pills, Best Pills*, p. 747.