

# My medicines

Name \_\_\_\_\_ Last updated \_\_\_\_\_

List everything you take: prescription medicines, medicines you bought, vitamins, supplements and herbal products.

Take a copy to every appointment and to the pharmacy.

| Medicine<br>Name on the box | Dose<br>For example 400 mg | How often<br>And the time of day | Started<br>Date | What it is for | Prescribed by<br>Or "bought" | Side effects or notes |
|-----------------------------|----------------------------|----------------------------------|-----------------|----------------|------------------------------|-----------------------|
|                             |                            |                                  |                 |                |                              |                       |
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## Allergies, and medicines that did not suit me

What happened

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# Is it helping?

Name \_\_\_\_\_

Pain: 0 = no pain, 10 = worst pain you can imagine.

Bleeding: 0 none · S spotting · L light · M medium · H heavy

Fill in one check at each appointment, or when you notice a change.

Medicine and dose \_\_\_\_\_ Started or changed on \_\_\_\_\_ Why \_\_\_\_\_

|                              | <b>Worst pain</b><br>Circle one | <b>Bleeding</b><br>Circle one | <b>Side effects</b><br>Mood, spotting, headaches, other | <b>Is it helping?</b><br>What changed in your day |
|------------------------------|---------------------------------|-------------------------------|---------------------------------------------------------|---------------------------------------------------|
| <b>Check 1</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 2</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 3</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |

Medicine and dose \_\_\_\_\_ Started or changed on \_\_\_\_\_ Why \_\_\_\_\_

|                              | <b>Worst pain</b><br>Circle one | <b>Bleeding</b><br>Circle one | <b>Side effects</b><br>Mood, spotting, headaches, other | <b>Is it helping?</b><br>What changed in your day |
|------------------------------|---------------------------------|-------------------------------|---------------------------------------------------------|---------------------------------------------------|
| <b>Check 1</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 2</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 3</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |

Medicine and dose \_\_\_\_\_ Started or changed on \_\_\_\_\_ Why \_\_\_\_\_

|                              | <b>Worst pain</b><br>Circle one | <b>Bleeding</b><br>Circle one | <b>Side effects</b><br>Mood, spotting, headaches, other | <b>Is it helping?</b><br>What changed in your day |
|------------------------------|---------------------------------|-------------------------------|---------------------------------------------------------|---------------------------------------------------|
| <b>Check 1</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 2</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |
| <b>Check 3</b><br>Date _____ | 0 1 2 3 4 5 6 7 8 9 10          | 0 S L M H                     |                                                         |                                                   |

## Questions for my doctor

For example: how long should I wait to see if it works?

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