Be an Active Member of Your Health Care Team

My Medicine Record

U.S. Department of Health & Human Services
Food and Drug Administration

Name: _____ Birth date: _____

	What I'm Using **Rx**-brand & generic name; **OTC**-name & active ingredients	What It Looks Like color, shape, size, markings, etc.	How Much	How to Use / When to Use	Start / Stop Dates	Why I'm Using / Notes	Who Told Me to Use / How to Contact
--- Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements ---							
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	1-15-06	Lowers blood pressure; check blood pressure once a week; blood test on 4-15-06	Dr. X (800) 555-1212

www.fda.gov/usemedicinesafely/my_medicine_record.htm

(888) INFO-FDA
www.fda.gov/usemedicinesafely

These are my medicines as of:

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