Be an Active Member of Your Health Care Team

My Medicine Record

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration
FDA

Name *(Last, First, Middle Initial)*: _____ Birth Date *(mm/dd/yyyy)*: _____

	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	1-15-11	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							

www.fda.gov/Drugs/ResourcesForYou/ucm079489.htm

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

These are my medicines as of
(Enter date as mm/dd/yyyy): _____

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