Over-the-Counter Medicines
(check all that you use regularly)

☐ Allergy Relief Medicine
☐ Antacids
☐ Aspirin/Other Pain, Headache or Fever Medicine
☐ Cold Medicine
☐ Cough Medicine
☐ Diet Pills
☐ Laxatives
☐ Herbal Supplements
☐ Sleeping Pills
☐ Vitamins
☐ Others (list below)

Remember to ask
your pharmacists, doctors or other health care providers:

1. What is the name of the medicine and what is it supposed to do?
2. Is this the brand name or generic name: How and when do I take it and for how long?
3. Are there any monitoring tests required with this medicine (for example, to check liver or kidney functions)?
4. What foods, drinks, other medicines or activities should I avoid while taking this medicine?
5. What are the possible side effects, and what do I do if they occur?
6. Will this new prescription work safely with the other prescription and non-prescription medicines I am taking?
7. Is there any written information available about the medicine? (In large print, or in a language other than English?)
**Personal Medical Data**

Please write in pencil

My name is __________________________

Date of Birth __________________________

Home Phone (____)________________________

Work Phone (____)________________________

**I am allergic to (please check):**

☐ Aspirin ☐ Insect Bites ☐ Antibiotics

☐ Other Medicines ☐ Food ☐ Codeine

**My medical condition includes:**

☐ Abnormal EKG ☐ Depression ☐ Hearing Impairment ☐ High Blood Pressure

☐ Angina ☐ Diabetes ☐ Heart Condition ☐ Pace Maker

☐ Arthritis ☐ Epilepsy ☐ Hemodialysis ☐ Visual Impairment

☐ Other

Doctor's Name ____________________________ Phone (____)________________________

Pharmacist's Name ____________________________ Phone (____)________________________

**Notify in Emergency:**

Name ____________________________ Phone (____)________________________

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**All Medicines I am Taking:**

Prescription:

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If you have questions about specific medicines, visit www.medlineplus.gov

(Please list your non-prescription medicines on the reverse side.)