## Medicine Check Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Questions**  | **Notes**  |
| **1. Name of medicine (brand name and generic name).** |  |
| **2. What is medicine used for and how does it work (e.g. protects my heart)?** |
| **3. When, how often, dosage, how long do I take this medicine?** |
| **4. Interactions with other medicines or food, drink, drugs?** |
| **5. Side effects?** |
| **6. Serious side effects I need to tell doctor about immediately.** |
| **7. Treatment goals (for blood pressure, uric acid, cholesterol, HbA1C) and tests I might need.** |