

Drug Safety Questionnaire

To the Doctor or Pharmacist:

I can take my medicine more safely if I know the answers to these questions. Thank you for your assistance.

Purpose of medicine:

Lab tests needed:

Date:

Result:

Date:

Result:

Name of medicine:

Brand: _____

Generic: _____

_____ 

Dose: _____

When to take: _____ am _____ pm

_____ 

Take medicine:

___ with food

___ an hour before or two hours after meals

_____ 

Foods to avoid, if any:

_____ 

Special precautions, if any:

_____ 

Contraindications or situations when this drug might be inappropriate, if any:

_____ 

Interacting medicines to avoid, if any:

_____ 

Common side effects:

_____ 

Serious symptoms:

(I should notify my doctor immediately at phone # _____)

_____ 

Date to discontinue, if ever: _____

(Photocopy this page and take it to your health care provider)