

## Please Review Your Medicines

It is very important that your doctor knows all the medicines you are taking.

Follow these steps:

Step 1. Remove any medicines you are not currently taking by **drawing a line through the drug's name**.

Step 2. For medicines you are currently taking, place a check (  ) in the **Taking as directed?** column next to the correct box indicating if you are taking the medication as described in the instructions.

Step 3. Place a check (  ) in the **Concerns** column next to any concern you may have about the medication.

### Your Current Medications Are

Medication	Instructions	Taking as directed?		Concerns	
<b>acetaminophen (TYLENOL) 120 mg suppository</b>	Place 1 suppository rectally every 4 hours as needed for Fever.	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> None	<input type="checkbox"/> Need Refill
		<input type="checkbox"/> only as needed		<input type="checkbox"/> Cost	<input type="checkbox"/> Side Effects
				<input type="checkbox"/> Other	
<b>ferrous sulfate 220 mg (44 mg iron)/5 mL solution</b>	Take 220 mg by mouth daily.	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> None	<input type="checkbox"/> Need Refill
		<input type="checkbox"/> only as needed		<input type="checkbox"/> Cost	<input type="checkbox"/> Side Effects
				<input type="checkbox"/> Other	

Step 4. Add the names of any other medicines you are currently taking that are not on the list. This includes prescription drugs, over-the-counter medicines, vitamins, and other supplements. For each drug, provide the dose and the instructions on how you take it. *Please don't worry if you have the exact spelling of your medications.*

Step 5. Place a check (  ) in the **Concerns** column next to any concern you may have about the medication listed.

### Your Additional Medicines Are

Medicine Name	Dose (i.e. 20mg)	How you take it	Concerns			
			<input type="checkbox"/>	Need Refill	<input type="checkbox"/>	Cost
			<input type="checkbox"/>	Side Effects	<input type="checkbox"/>	Other
			<input type="checkbox"/>	Need Refill	<input type="checkbox"/>	Cost
			<input type="checkbox"/>	Side Effects	<input type="checkbox"/>	Other
			<input type="checkbox"/>	Need Refill	<input type="checkbox"/>	Cost
			<input type="checkbox"/>	Side Effects	<input type="checkbox"/>	Other