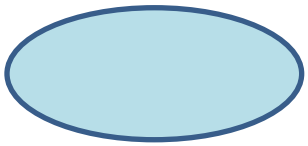
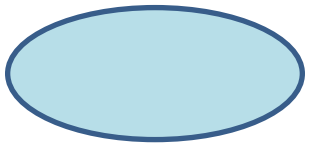
Pill Form

Check the list of **Common Side Effects** should you experience side effects on the back of this form **before** starting your medications.



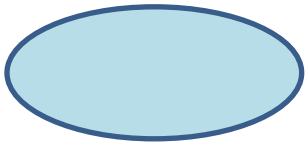
_____
Medication Name

_____
Number of Pills



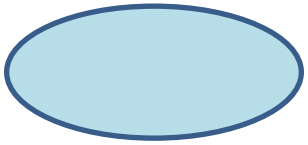
_____
Medication Name

_____
Number of Pills



_____
Medication Name

_____
Number of Pills



_____
Medication Name

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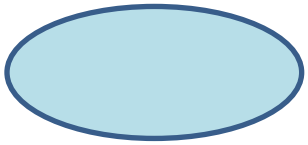
Number of Pills



_____
Medication Name

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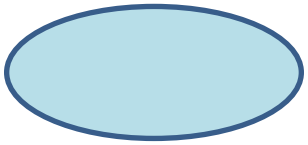
Number of Pills



_____
Medication Name

_____
Number of Pills

DOT Staff: Fold here and laminate after filling in blanks.

Common Side Effects

If you have any of the following symptoms, **DO NOT** take your medications and **DO NOT** record your eDOT session. For **emergencies,** or for side effects that occur outside normal business hours go to an emergency department for medical care, then call and leave a message at the number below on the *Contact Card.*

Tiredness	Weakness
Nausea	Vomiting
Loss of appetite	Weight loss
Stomach pain	Yellow skin or eyes (jaundice)
Diarrhea	Fever
Sore muscles	Joint pain
Dizziness	Headache
Vision changes	Eye pain
Itching	Rash

Change in color of urine or stool
Tingling or numbness in fingers or toes

Local Health Department Contact

_____
Name of Contact Person

_____
Phone Number for Contact Person

Keep this card for your reference for the duration of your treatment.