UFT WELFARE FUND
Member Awareness Program

PERSONAL MEDICATION QUESTION GUIDE

Complete this record prior to the visit to your doctor. Please list all prescription and over-the-counter medications you may be taking (e.g., aspirin, headache or pain medications). To protect your privacy, do not write your name on this form.

Name of medications you are **currently** taking:

Medicine:____________________ Dosage:________________ (times per day)______

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Medicine:____________________ Dosage:________________ (times per day)______

If your doctor prescribes a "**new**" medication, ask the questions below and write the answers in the spaces provided.

Name of medication:______________________Dosage:______________________

Is this drug a brand or generic?____

Can I use a generic?____

How and when should I take this drug?______________________________________

What is this medicine for and what effects should I expect?_____________________

Is this drug replacing a medicine I have been using?__________________________

Will there be any problems (interactions) taking this drug with my other medications?

____

Are there any possible side effects? What should I do if a side effect occurs?

____

Should I avoid any foods, activities or supplements with this drug?_______________

____

Members should photocopy this form and keep it available for future visits.