DOT MEDICATION SHEET PAGE ___ OF ____

Name: _____ DOB: _____ Race: _____ Sex: M / F Date medication started: _____
Address: _____ Telephone: (home) _____ (work) _____ Month/Year _____

Medication	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Isoniazid____mg PO _x wk																															
Rifampin ____mg PO__ x wk																															
Pyrazinamide__mg PO__x wk																															
Ethambutol___mg PO__ x wk																															
Pyridoxine____mg PO__x wk																															
Rifamate____mg PO___x wk																															
Rifapentine____mg PO 1x wk																															
Time of DOT																															
# of doses this month_____															**# weeks of treatment this month _____**															
Side effects: If present write √ and write F/U under comments. If absent, write Ø																															
Nausea/vomiting/abdominal pain																															
Jaundice/dark urine/yellow eyes																															
Headache/skin rash/weakness																															
Fatigue/flu-like symptoms																															
Unsteady gait/behavioral change																															
Visual problems/change in hearing																															
Tingling in extremities/ bleeding problems/ joint pain																															
Loss of appetite/weight loss																															
Coughing/coughing up blood																															
Fever/chills/night sweats																															
																														Total doses to date	_____

	Initials	Signature of Person Observing Medication	Initials	Signature of Person Observing Medication
Sputum Date: _____ Sputum Date: _____				
Sputum Date: _____ Sputum Date: _____				

Special Instructions/Comments: