DOT MEDICATION SHEET

Name: _____ DOB: _____ Race: ___ Sex: M / F Date Medication Started _____ Page _____ of _____

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																															
Time of DOT																															
Side Effects: If present check and write F/U under comments. If absent, -0-																															
Nausea / Vomiting / Abdominal Pain																															
Jaundice / Dark Urine / Yellowish Eyes																															
Headache / Skin Rash / Weakness																															
Fatigue / Flu-like Symptoms																															
Unsteady Gait / Behavioral Changes																															
Visual Problems / Changes in Hearing																															
Tingling in Extremities / Bleeding Problems / Joint Pain																															
Loss of Appetite / Weight Loss																															
Coughing / Coughing up Blood																															
Fever / Chills / Night Sweats																															

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

Special Instructions / Comments: