

Health Literacy Now

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My New Medication Form

Name

Allergies

New Pill name

How much?

How often do I take it?

What is this pill for?

What time of the day do I take it?

Morning

Noon

Night

Bedtime



What are the main side effects?

1. _____

2. _____

3. _____

Do I need to take the pill with food?

Yes _____ **No** _____

Do I need any blood test for this new pill? _____

Do I need to change my diet for this pill? _____

Do I need to watch out for any signs? _____

Who do I contact if I have any questions?

Name _____ **Phone** _____