PTO for SIDE EFFECTS DIARY...

Adherence Support Chart

Schedule planner:

Use the top chart to plan your pill timetable with your doctor, nurse or pharmacist. Use shading to indicate any diet restrictions - either where it is important that you take your meds with food, or avoiding a certain type of food, or whether you need to take them on an empty stomach.

	AM							PM												AM		
Drug name	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3

Adherence check:

Once you have worked out a daily regimen above, use the table below to mark off each dose after taking. Do this for the first few weeks. Write the name of the drug and the time you need to take it in the top boxes. Use a different box for each drug. Then tick off the dose and write the time you actually took the dose in the sections underneath. Use a photocopy, or draw a new version yourself to use for the second and third weeks or if you need a larger table. This will help you know how well you are doing and this will be helpful when you next see your doctor.

Week date: ____________________________________

		Drug names + times: AM			Drug names + times: PM		
	add drug names + times from the schedule above in these boxes						
Monday	write the actual time that you took each dose each day when you tick off these boxes						
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							

From the i-Base *Guide to Combination Therapy,* available free in bulk for use in clinics. i-Base is a registered charity no1081905
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PTO for ADHERENCE PLANNER...

Side Effects Diary

Side effects diary:

Use this page to record any changes in your health that could be related to side effects as this will help you describe them to your doctor. Some of the most common side effects are listed below but include others even if they are not listed here.

1 Tingling in hands or feet
2 Pain in hands or feet
3 Nausea/vomiting
4 Headache
5 Feeling tired
6 Dry skin
7 Rash
8 Diarrhoea
9 Stomach pains
10 Hair loss
11 Body shape changes
12 Weight gain
13 Weight loss
14 Changes in taste or appetite
15 Injection site reactions (T-20)
16 Disturbed sleep / vivid dreams
17 Sexual problems
18 Feeling anxious/nervous
19 Visual changes
20 Other(s) specify

Side effect or symptoms	Day	Time(s)	Scale: 1= mild, 5 = severe
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5
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Other comments & questions to ask your doctor:

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