FULL LIST PLUS 14-DAY SYMPTOM RECORD

Medicines and Gut Record

List everything you take, then mark the day any medicine starts or changes. If a symptom line rises a few days later, you have something specific to show your pharmacist.



SHEET 20

Name _____ **Pharmacy** _____ **Day 1 is** _____

MEDICINE, VITAMIN, HERB OR SUPPLEMENT	WHAT FOR	DOSE	WHEN I TAKE IT	WITH FOOD OR EMPTY STOMACH	STARTED	PRESCRIBED, OR BOUGHT MYSELF

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
GUT SYMPTOMS, 0 NONE TO 10 WORST														
Gut symptoms ● nausea ○ tummy pain ☐ heartburn 10 8 6 4 2 0														
Stool type 1 to 7														
Movements how many														
All doses taken as directed	○	○	○	○	○	○	○	○	○	○	○	○	○	○
New or changed medicine	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Changes agreed with my doctor or pharmacist Only changes a professional has agreed go here.

DATE	CHANGE AGREED, EXACTLY AS ADVISED	ADVISED BY	REVIEW DATE

Never stop, skip, switch or re-time a prescribed medicine to test a symptom. Bring this sheet to a pharmacist instead. Include painkillers bought over the counter, iron, vitamins and herbs. Vomiting blood, black sticky stool or sudden severe tummy pain is an emergency; do not put dark stool down to iron if it is tarry.