

MEDICATION TRACKER

The 3 Months of Daily Isoniazid Plus Rifampin Schedule for Latent Tuberculosis (TB) Infection

Your Medication Schedule (Providers: Indicate the appropriate number of pills and day)

Medicine	Number of pills per week	Frequency	Duration	Doses
Isoniazid: _____ mg	TOTAL pills: _____	Once a day	3 months	90
Rifampin: _____ mg	Isoniazid: _____			
	Rifampin: _____			

Your doctor may also add Vitamin B6 to your treatment plan.

Keeping Track of Your Treatment

On the table below, check the box and write the date to show when you took your medicine.

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Example May 4-10	<input checked="" type="checkbox"/> 05/04	<input checked="" type="checkbox"/> 05/05	<input checked="" type="checkbox"/> 05/06	<input checked="" type="checkbox"/> 05/07	<input checked="" type="checkbox"/> 05/08	<input checked="" type="checkbox"/> 05/09	<input checked="" type="checkbox"/> 05/10
Week 1 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 2 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 3 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 4 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 5 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 6 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 7 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 8 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 9 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 10 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 11 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Week 12 _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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Centers for Disease Control and Prevention
National Center for HIV/AIDS,
Viral Hepatitis, STD, and
TB Prevention

CS321485A

SYMPTOM CHECKLIST

The 3 Months of Daily Isoniazid Plus Rifampin Schedule for Latent Tuberculosis (TB) Infection

Patient Name: _____



Normal Side Effects

Most people can take their TB medicines without any problems. The rifampin medicine may cause your urine (pee), saliva, tears, or sweat to appear an orange-red color. This is normal and the color may fade over time. When taking Isoniazid, your doctor may have you take vitamin B6 with your medication.



STOP taking your medicine and **CALL** your TB doctor or nurse right away if you have any of the problems below:

- | | |
|---|---|
| <input type="checkbox"/> Less appetite, or no appetite for food | <input type="checkbox"/> Yellowing skin or eyes |
| <input type="checkbox"/> An upset stomach or stomach cramps | <input type="checkbox"/> Severe weakness or tiredness |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Severe diarrhea or light-colored stools (poop) | <input type="checkbox"/> Head or body aches |
| <input type="checkbox"/> Brown, tea-colored, or cola-colored urine | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Easy bruising or bleeding | <input type="checkbox"/> Tingling or numbness in your hands or feet |
| <input type="checkbox"/> Rash or itching | |



Please talk to your doctor or nurse if you have any questions or concerns about treatment for latent TB infection.

Doctor/Clinic Contact Information

Name of the staff caring for you: _____

Phone number: _____

Address: _____

Hours: _____

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