

2. Name of non-prescription medications <i>Medicines purchased without a prescription, such as Tylenol, laxatives, allergy, cough and cold products</i>	Directions <i>How do you use this medication? e.g. couple of times a week</i>	Purpose <i>Why do you take it?</i>
<input type="checkbox"/> Check this box if you do <u>not</u> take any non-prescription medications		

3. Vitamins, minerals, herbal or natural products <i>E.g. St. John's Wort, calcium, multi-vitamins</i>		Directions <i>How do you take the product?</i>	Used for how long?	Purpose <i>Why do you take it?</i>
Brand name	Ingredients			
<input type="checkbox"/> Check this box if you do <u>not</u> take any vitamins, minerals, herbal or natural products				

Please provide any other comments regarding medications that will help your cancer care team:
E.g. trouble opening child-resistant containers or trouble swallowing tablets

Date completed _____ / _____ / _____
month day year

Please email the completed form to patienthistory@saskcancer.ca and include your city/town in the subject line.