Iowa Department of Public Health
Tuberculosis Control Program DOT Log

Name (Last, First, Middle):				**DOB (D/M/Y):**		**Gender:** ☐ Male ☐ Female	
Street Address:			**City:**	**Med/Strength**	**Dose/# tabs**	**Start Date**	**End Date**
Phone (home/work/ cell):			**Zip:**				
Date:	**Printed Name:**	**Signature:**	**Initials:**	**DOT Start Date:**			
				DOT End Date:			
				DOT Site: ☐ Home ☐ Work			
				☐ Clinic ☐ Other_____			

Day of Month	Dose #	Initials of DOT Personnel	Time of DOT	Side Effects: If present, check and write progress note. If absent, check in the "none" column.														
				None	Nausea/ Vomiting	Abdominal Pain	Headache	Loss of Appetite	Jaundice	Numbness/ tingling	Rash	Fatigue	Joint Pain	Vision Change	Hearing Change	Other	Dr. Notified of adverse reaction	Comments
1		☐ Self																
2		☐ Self																
3		☐ Self																
4		☐ Self																
5		☐ Self																
6		☐ Self																
7		☐ Self																
8		☐ Self																
9		☐ Self																
10		☐ Self																
11		☐ Self																
12		☐ Self																
13		☐ Self																
14		☐ Self																
15		☐ Self																
16		☐ Self																
17		☐ Self																
18		☐ Self																
19		☐ Self																
20		☐ Self																
21		☐ Self																
22		☐ Self																
23		☐ Self																
24		☐ Self																
25		☐ Self																
26		☐ Self																
27		☐ Self																
28		☐ Self																
29		☐ Self																
30		☐ Self																
31		☐ Self																