



The Mastocytosis Society

The Mastocytosis Society • P.O. Box 731 • Brenham, TX 77834

MEDICATION BY INDICATION ORGANIZER

MAJOR ILLNESSES

INDICATION #1: <u>Mastocytosis</u>		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
EXAMPLE ONLY Gastrocrom 100 mg ampules	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	200 mg -2 ampules	4x Dy 30 min before meals	Stabilize mast cells in GI tract; Brain fog
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #2: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

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INDICATION #3: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #4: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

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INDICATION #5: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #6: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

OTHER ILLNESSES _____

INDICATION #7: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

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INDICATION #8: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #9: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #10: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #11: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #12: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

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INDICATION #13: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #14: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #15: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #16: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #17: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

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INDICATION #18: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #19: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			

INDICATION #20: _____		MEDICATION LIST:		
Drug Name & Strength	Generic	Dosage	How Often	Reason for taking this medication
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Y <input type="checkbox"/> N			