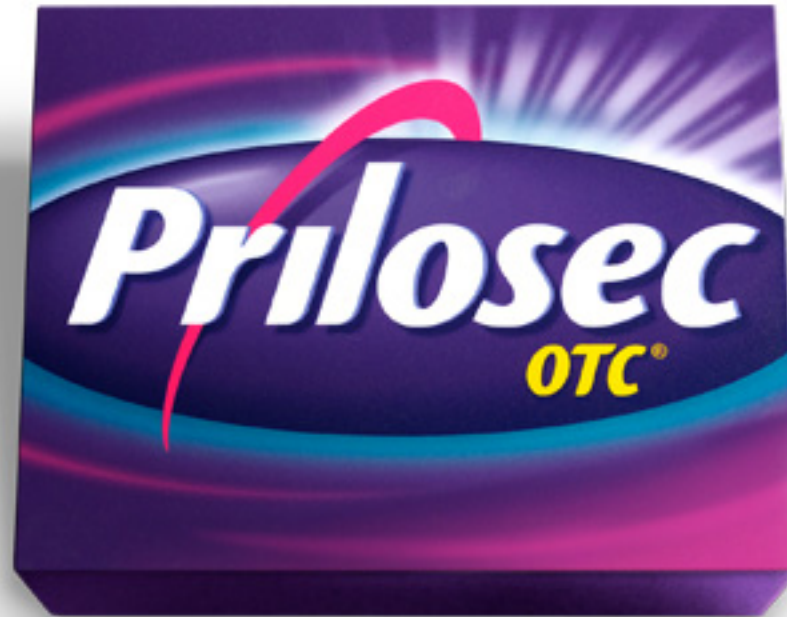


**DO I HAVE
FREQUENT HEARTBURN?**



COMPLETE THE 14-DAY SYMPTOM DIARY AND FIND OUT

TRACK YOUR SYMPTOMS TO FIND OUT IF YOU SUFFER FROM FREQUENT HEARTBURN

If you experience heartburn two or more days per week, Prilosec OTC® may be for you.

Keep this diary — it's a great reference for you, as well as for your health care provider. For the next 14 days, each time you experience heartburn, write down the date, time of occurrence, factors that seem to contribute to your heartburn and any symptoms that might be related. Then write down what you do to treat the heartburn, whether it works, and for how long it works.

QUESTIONS:



SYMPTOMS

- Describe your symptoms.
(eg, burning in chest, feeling of acid rising in the throat, asthma, hoarseness, stomach pain)
- How severe were these symptoms?



IMPACT

- Did the symptoms affect your ability to sleep, work, or do any other activities?
- How long did the symptoms last?



POTENTIAL TRIGGERS

- What did you eat and drink?
- Were you experiencing stress?
- Before the onset of symptoms, did you exercise? Eat spicy or greasy food? Smoke? Lie down soon after eating?



TREATMENT

- Did you take any medicines—over-the-counter or prescription—to relieve the heartburn? Record all, including antacids, H2 blockers, PPIs (including Prilosec OTC), herbal remedies, home remedies.
- Did the medicine provide relief?
- If so, for how long did it provide relief?

PRILOSEC OTC: HEARTBURN DIARY

DAY	DID YOU HAVE HEARTBURN TODAY?	WHAT WERE YOUR HEARTBURN SYMPTOMS?	WHAT IMPACT DID HEARTBURN HAVE ON YOUR DAY?	WHAT WERE THE POTENTIAL TRIGGERS?	DID YOU TREAT YOUR HEARTBURN?
1	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
2	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
3	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
4	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____

PRILOSEC OTC: HEARTBURN DIARY

DAY	DID YOU HAVE HEARTBURN TODAY?	WHAT WERE YOUR HEARTBURN SYMPTOMS?	WHAT IMPACT DID HEARTBURN HAVE ON YOUR DAY?	WHAT WERE THE POTENTIAL TRIGGERS?	DID YOU TREAT YOUR HEARTBURN?
5	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
6	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
7	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____

7-DAY HEARTBURN EVALUATION:

TOTAL DAYS YOU EXPERIENCED HEARTBURN: _____

NOTES: _____

PRILOSEC OTC: HEARTBURN DIARY

DAY	DID YOU HAVE HEARTBURN TODAY?	WHAT WERE YOUR HEARTBURN SYMPTOMS?	WHAT IMPACT DID HEARTBURN HAVE ON YOUR DAY?	WHAT WERE THE POTENTIAL TRIGGERS?	DID YOU TREAT YOUR HEARTBURN?
8	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
9	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
10	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
11	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____

PRILOSEC OTC: HEARTBURN DIARY

DAY	DID YOU HAVE HEARTBURN TODAY?	WHAT WERE YOUR HEARTBURN SYMPTOMS?	WHAT IMPACT DID HEARTBURN HAVE ON YOUR DAY?	WHAT WERE THE POTENTIAL TRIGGERS?	DID YOU TREAT YOUR HEARTBURN?
12	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
13	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____
14	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, at what times? <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Burning in chest <input type="checkbox"/> Acid reflux <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Cough / sore throat <input type="checkbox"/> Other: _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	What medicine or treatment(s)? _____ _____ Did your treatment(s) provide relief? _____

14-DAY HEARTBURN EVALUATION:

TOTAL DAYS YOU EXPERIENCED HEARTBURN: _____

NOTES: _____

FREQUENT HEARTBURN IS HEARTBURN OCCURRING TWO OR MORE TIMES PER WEEK. IF YOU SUFFER FROM FREQUENT HEARTBURN, PRILOSEC OTC MAY BE FOR YOU. TALK WITH YOUR DOCTOR ABOUT THE INFORMATION YOU TRACKED IN YOUR 14-DAY SYMPTOM DIARY.