



## **MEDWATCH**

### **Consumer Voluntary Reporting**

#### **(FORM FDA 3500B)**

#### **When do I use this form?**

- You were hurt or had a bad side effect (including new or worsening symptoms) after taking a drug or using a medical device or product.
- You used a drug, product, or medical device incorrectly which could have or led to unsafe use.
- You noticed a problem with the quality of the drug, product or medical device.
- You had problems with how a drug worked after switching from one maker to another maker.

#### **Don't use this form to report:**

- Vaccines – report problems to the Vaccine Adverse Event Reporting System (VAERS).
- Investigational drugs or medical devices (those being studied) – report problems to your doctor or to the contact person listed in the clinical trial.
- Animal Drug, Device, Pet Food and Livestock Feed Problems – report problems to [FDA's Center for Veterinary Medicine](#)
- Tobacco products – report health or product problems to the Safety Reporting Portal (SRP) <https://www.safetyreporting.hhs.gov> or call 1-877-287-1363
- Food, cosmetic or dietary supplement products – report problems to the SRP <https://www.safetyreporting.hhs.gov/SRP2>

#### **Will the information I report be kept private?**

The FDA recognizes that privacy is an important concern, so you should know:

- We ask only for the name and contact information of the person filling out the form in case we need more information.
- Your name and contact information may be shared with the company that makes the product to help them better understand the problem you are reporting, unless you request otherwise (see Section F).

#### **What types of products should I use this form for?**

- Prescription and over-the-counter drugs, therapeutic biologics and biosimilars including monoclonal antibodies, and biologics, such as human cells and tissues used for transplantation (for example, tendons, ligaments, and bone) allergenics and gene therapies.
- Medical devices, including any health-related kit, test, tool, or piece of equipment (such as breast implants, pacemakers, diabetes glucose-test kits, hearing aids, breast pumps, and many others)
- Cosmetics such as moisturizers, makeup, shampoos and conditioners, face and body washes, deodorants, nail care products, hair dyes and relaxers, and tattoos
- Foods (including beverages and ingredients added to foods)

#### **Are there specific instructions for filling out the form?**

- Fill in as much information as possible and send in the report even if you do not have all the information.
- You can fill out this form yourself or have someone fill it out for you. If you need help, you may want to talk with your health professional.
- Feel free to include or attach an image of the product. Please do not send the products to the FDA.

#### **How will I know the FDA has received my form?**

- You will receive a reply from the FDA after we receive your report. We will personally contact you only if we need additional information.
- Your report will become part of a database so that it can be reviewed and compared to other reports by an FDA safety evaluator who will determine what steps to take.

#### **How can I contact the FDA if I have questions?**

Toll-free line: 1-800-332-1088

To report online: [www.fda.gov/medwatch/report.htm](http://www.fda.gov/medwatch/report.htm)

#### **The information below applies only to requirements of the Paperwork Reduction Act of 1995.**

The burden time for this collection of information is estimated to average 30 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the address to the right:

*OMB Statement: "An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."*

Department of Health and Human Services  
Food and Drug Administration  
Office of Chief Information Officer  
Paperwork Reduction Act (PRA) Staff  
[PRASStaff@fda.hhs.gov](mailto:PRASStaff@fda.hhs.gov)

**DO NOT SEND YOUR COMPLETED FORM TO THIS PRA STAFF ADDRESS.**



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Food and Drug Administration

Form Approved: OMB No. 0910-0291  
Expiration Date: 01/31/2025  
(See PRA Statement on preceding  
general information page)

**MEDWATCH**  
**Consumer Voluntary Reporting**  
**(FORM FDA 3500B)**

**Note:** For date prompts of "dd-mmm-yyyy" please use 2-digit day, 3-letter month abbreviation, and 4-digit year; for example, 01-Jan-1900.

**Section A – About the Problem**

1. What kind of problem was it? (Check all that apply)

- Were hurt or had a bad side effect (including new or worsening symptoms)
- Used a product incorrectly which could have or led to a problem
- Noticed a problem with the quality of the product
- Had problems after switching from one product maker to another maker

2. Did any of the following happen? (Check all that apply)

- Hospitalization – admitted or stayed longer
- Required help to prevent permanent harm
- Disability or health problem
- Birth defect
- Life-threatening
- Death (include date) (e.g., 01-Jan-1900):
- Other serious/important medical incident

3. Date the problem occurred (e.g., 01-Jan-1900)

4. Tell us what happened, how it happened or why it happened. (Include as many details as possible. FDA may reach out to you for any additional documents if necessary)  
Characters Remaining (max. 4,000):

For more information, visit <http://www.fda.gov/MedWatch>

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

5. Relevant Tests/Laboratory Results	Date (e.g., 01-Jan-1900)	Relevant Tests/Laboratory Results	Date (e.g., 01-Jan-1900)

**Additional Comments**

Characters Remaining (max. 2,000):

### Section B – Product Availability

- |  |   |   |                              |
|--|---|---|------------------------------|
| 1. Do you still have the product in case we need to evaluate it? (Do not send the product to FDA. We will contact you directly if we need it.) | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | 2. Do you have a picture of the product? (check yes if you are including a picture) | <input type="checkbox"/> Yes |
|--|---|---|------------------------------|

*For a problem with a product, including*

- prescription or over-the-counter medicine
- biologics, such as blood transfusions, gene therapies, and human cells and tissue transplants (for example, tendons, bone, and corneas)
- nutrition products, such as vitamins and minerals, herbal remedies, infant formulas, and medical foods
- cosmetics or make-up products
- foods (including beverages and ingredients added to foods)



*For a problem with a medical device, including*

- any health-related test, tool, or piece of equipment
- health-related kits, such as glucose monitoring kits or blood pressure cuffs
- implants, such as breast implants, pacemakers, or catheters
- other consumer health products, such as contact lenses, hearing aids, and breast pumps



**(Skip Section C)**

*For a health or product problem with a food, cosmetic, dietary supplement or tobacco product*




Go to <https://www.safetyreporting.hhs.gov/SRP2>

### Section C – About the Products


1. This report is about  Cosmetic  Dietary Supplement  Food/Medical Food  Other
2. Name(s) of the product as it appears on the box, bottle, or package (Include as many names as you see)
3. Check if therapy is on-going
4. Name(s) of the company that makes (or compounds) the product

For more information, visit <http://www.fda.gov/MedWatch>

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5. Product Type (check all that apply)					
<input type="checkbox"/> Over-the-Counter		<input type="checkbox"/> Compounded by a Pharmacy or an Outsourcing Facility		<input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar	
6. Expiration date (e.g., 01-Jan-1900)		7. Lot number		8. NDC number	
9. Strength (for example, 800mg/160 mg or 20 mg)					
10. Quantity (for example, 2 pills, 2 puffs, or 1 teaspoon, etc.)		11. Frequency (for example, twice daily or at bedtime)		12. How was it taken or used (for example, by mouth, injection, or on the skin)?	
13a. Date the person first started taking or using the product (e.g., 01-Jan-1900):		<input type="text"/>		15. Why was the person using the product? (such as, what condition was it supposed to treat)	
13b. Date the person stopped taking or using the product (e.g., 01-Jan-1900):		<input type="text"/>			
13c. Date the person reduced dose of the product (e.g., 01-Jan-1900):		<input type="text"/>			
14. Give best estimate of duration		Unit			
16. Did the problem stop after the person reduced the dose or stopped taking or using the product?			17. Did the problem return if the person started taking or using the product again?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Didn't restart		
 <b>Go to Section E (Skip Section D)</b>					

### Section D – About the Medical Device

1. Name of medical device					
2. Name of the company that makes the medical device					
3. Model number	4. Catalog number	5. Lot number	6. Serial number	7. UDI number	8. Expiration date (e.g., 01-Jan-1900)
					<input type="text"/>
9. Was someone operating the medical device when the problem occurred?		If yes, who was operating it?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> The person who had the problem		<input type="checkbox"/> A health professional (such as a doctor, nurse, or aide)	
		<input type="checkbox"/> Someone else (Please explain who)			
10. For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)					
Date the implant was put in (e.g., 01-Jan-1900)			Date the implant was taken out (If relevant) (e.g., 01-Jan-1900)		
<input type="text"/>			<input type="text"/>		
 <b>Go to Section E</b>					

For more information, visit <http://www.fda.gov/MedWatch>

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**Section E – About the Person Who Had the Problem**

1. Person's Initials	2a. Sex: Enter the patient's sex at birth (the sex that a person has or was assigned to at birth). <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Decline to answer	2b. Gender: Enter the patient's current gender (how the patient thinks of themself). <input type="checkbox"/> Cisgender man/boy (gender corresponds with birth sex) <input type="checkbox"/> Cisgender woman/girl (gender corresponds with birth sex) <input type="checkbox"/> Transgender man/trans man/ female-to-male (FTM) <input type="checkbox"/> Transgender woman/trans woman/ male-to-female (MTF) <input type="checkbox"/> Other gender category; please specify: <input type="checkbox"/> Decline to answer	
3. Age (specify unit of time for age) <input type="checkbox"/> Year(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Day(s)		4. Date of Birth (e.g., 01-Jan-1900) <input style="width: 100px; height: 20px;" type="text"/>	5. Weight (Specify lbs or kg) <input type="checkbox"/> lb <input type="checkbox"/> kg
6. Ethnicity (Choose only one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		7. Race (Choose all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
8. List known medical conditions. (Such as diabetes, high blood pressure, cancer, heart disease, or others) <span style="float: right;">Characters Remaining (max. 2,000):</span>			
9. Please list all allergies (such as to drugs, foods, pollen or others)			
10. List any other important information about the person (such as tobacco product use, pregnancy, alcohol use, etc.)			
11. List all current prescription medications and medical devices being used. <span style="float: right;">Characters Remaining (max. 2,000):</span>			

12. List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Characters Remaining (max. 2,000):

 **Go to Section F**

### Section F – About the Person Filling Out This Form

We will contact you only if we need additional information.

1. Last name		2. First name	
3. Number/Street		4. City and State/Province	
5. ZIP or Postal code		6. Country	
7. Telephone number	8. Email address		9. Today's date (e.g., 01-Jan-1900) <input type="text"/>
10. Did you report this problem to the company that makes the product (the manufacturer/compounder)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box: <input type="checkbox"/>			

### Send This Report by Mail or Fax

Keep the product in case the FDA wants to contact you for more information. Please do not send products to the FDA. Mail or fax the form to: MedWatch, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20852; FAX: 800-332-0178 (toll-free).

**Thank you for helping us protect the public health.**

For more information, visit <http://www.fda.gov/MedWatch>

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