Participant ID: **Participant Initials:** **Clinical Center:**

Site: **Visit Number:** **CRF Date:** **RC ID:**

CONCOMITANT MEDICATIONS

1. ***Within the last 30 days,*** have you taken any medications, including over-the-counter medications, and prescription medications? ❑$_1$ Yes ❑$_0$ No

   a. If ***YES***, list the number of medications to be recorded at this visit and complete the table below. ___ ___ ___

Line Number	Primary Drug Code	Primary Medication Name	Combination Drug	Component Drug Code	Component Medication Name	Total Dose	Unit	Frequency	Route
__ __ __									
__ __ __									
__ __ __									
__ __ __									
__ __ __									
__ __ __									
__ __ __									
__ __ __									

Combination Drug	Unit	Frequency	Route
1 = Yes 0 = No 88 = Don't Know	1 = mg 2 = mcg 3 = tablets 4 = ml/cc 5 = tsp 6 = tbsp 7 = oz 8 = drops 9 = spray 10 = units 11 = mEq 12 = application 13 = patch 98 = Other	1 = qd 2 = bid 3 = tid 4 = qid 5 = PRN 6 = every 4 hours 7 = every other day 8 = twice weekly 9 = every week 10 = every 2 weeks 11 = every month 98 = Other	1 = Oral 2 = IV 3 = IM 4 = SC 5 = Topical 6 = Rectal 7 = Nasal 8 = Transdermal 9 = Inhalant 10 = Sublingual 11 = Ophthalmic 98 = Other