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	Drug Code	Medication Name	Total Daily Dose	Unit 1 = mg 7 = oz 2 = mcg 8 = drops 3 = tablets 9 = spray 4 = ml/cc 10 = units 5 = tsp 98 = Other 6 = tbsp	Frequency 1 = qd 2 = bid 3 = tid 4 = qid 5 = PRN 98 = Other	Route 1 = Oral 7 = Nasal 2 = IV 8 = Transdermal 3 = IM 9 = Inhalant 4 = SC 10 = Sublingual 5 = Topical 98 = Other 6 = Rectal
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						
__ __ __						