Participant ID: Participant Initials: Clinical Center:

Site: RC ID:

CONCOMITANT MEDICATIONS

Reset Patient / RC

Reset All

Please list any medications, including over-the-counter medications, and prescription medications that the participant has taken ***within the last 30 days***.

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