



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		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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