Participant ID: Participant Initials: Clinical Center:

Site: Visit Number: CRF Date: / / RC ID: Reset Patient / RC

Reset All

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