Persons using assistive technology may not be able to fully access information in this file. For assistance, e-mail niddk-cr@imsweb.com. Include the Web site and filename in your message.

Participant ID: ____ Participant Initials: ____ Clinical Center: ____

Site: ____ Visit Number: ____ CRF Date: ____ / ____ / ____ RC ID: ____

CONCOMITANT MEDICATIONS

Reset Patient / RC

Reset All

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 2 = mcg 3 = tablets 4 = ml/cc 5 = tsp 6 = tbsp 7 = oz 8 = drops 9 = spray 10 = units 98 = Other	Frequency 1 = qd 2 = bid 3 = tid 4 = qid 5 = PRN 98 = Other	Route 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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