CRISP

OTC/Prescribed/Other Drugs

CRISP -FORM # 5

Missing Codes:
A-Participant refused
B-Reading not possible
C-Investigator forgot

Use Missing Codes to indicate reason for absent information.

This form is to be completed at the participant's first clinic visit during baseline physical exam.

1. **Date of Visit**: _______ / _______ / _______ DVDATE
Month Day Year

2. **Smoking and Tobacco:**

2a. Do they currently smoke cigarettes (circle): no yes CSYN **2b. If yes, Cigarettes** (packs per year) __PPY__

2c. If no, Year Quit Smoking (n/a for never smoked): _QSM_ / _QSY_
Month Year

If they use any of the following products, please indicate below either the number of years used or the average number per year:

2d. Pipe (number of years)_PIPE_ **2e. Cigars** (number per year) _CIGAR_ **2f. Chewing tobacco** (number of years) _CHEWT_

3. **Caffeinated Coffee/Tea/Other caffeinated beverage/Alcohol Intake:**

3a. Average number of cups of caffeinated coffee/tea daily over the last month: _____ CUPCAF

Number of years (caffeinated coffee/tea use): ______ CAFNOY

3b. Average number of glasses of other caffeinated beverages daily over the last month: _________ GLASSC

3c. Average number of alcoholic drinks daily over the last month:_NAD_ **Number of years** (alcohol consumption): _____NOYAD
(drink = 1 bottle of beer, 4 oz. of wine, 1 shot of liquor)

3d. N/A __________ NACA

4. **Analgesic Use History:** (**Complete** if at **least 100** analgesic tablets in **entire** life)
Record the average number per month over the last year.

4a. Acetaminophen tablets: ___ACETT___
Avg. number / month

4b. Aspirin tablets: ____ASPRT___
Avg. number / month

4c. Combination analgesics: __COMBOT___
Avg. number / month

4d. NSAID's: _____NSAIDT____
Avg. number / month

4e. N/A (check if none of the above are applicable) ___________ NAAU

5. **Drug Use** (circle all that were in use in the last year**):**

None	Marijuana	Cocaine	Heroin	Angel Dust	Other
DUN	DUM	DUC	DUH	DUAD	DUO

If Other, Specify: ______OTHR________

6. **Natural Product Use History:** (If yes is circled, please specify number of years of usage and products)

6a. Protein supplement: yes no PSYN Number of years used: _PSYRU_ Specify:_____PSTXT___________

6b. Other: yes no ONPYN Number of years used: _ONPYRU_ Specify:__________ONPTXT_____________

Clinical Center: ___________

Participant ID: ____________

Visit Number: ____________

7. Current OTC and Prescribed Medication Use:

Does participant use over-the-counter or prescribed medications? (circle one): no yes UDYN

IF yes, then list the name of medications taken (not dosage):

# LINE	Medication
1	MEDS
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

CRISP Member Completing this Form:___CMIDNUM____ Date form completed: ________ / ________ / _______ CDDATE
Month Day Year

Contents of form reviewed by Principal Investigator (required signature):___________________________

Date Principal Investigator signed: _______ / _______ / _______ RSDATE
Month Day Year

Data Entry Status: Please check to indicate that the above information has been entered ☐

Data Entry Person:________DEIDNUM__________ Date Form Entered: _______ / _______ / _______ DEDATE
Month Day Year

Clinical Center: ___PCCN___
Participant ID: __PKDID___
Visit Number: _____________