EDIC
**EPIDEMIOLOGY OF
DIABETES INTERVENTIONS
AND COMPLICATIONS**

EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS

Current Medication Form

This form should be completed at the Annual Visit as part of the Annual History and Physical Examination if there is a positive response to questions that inquire about the patient's use of medication. Unless otherwise indicated, questions refer to the patient's experience since the last completed annual clinic visit.

Send the completed form to the Coordinating Center in the monthly forms mailing. Retain a copy in the clinic files.

A. IDENTIFYING INFORMATION

1. Clinic Number: __ __   4. Date Form Completed: __ __/__ __/__ __
                                                           Month Day   Year
2. Patient ID Number: __ __ __ __ __
                                   5. EDIC Follow-Up Year   __ __
3. Patient's Initials: __ __ __

B. CURRENT MEDICATION

	No	Yes
1. Has the patient used over-the-counter medications?	(1)	(2)

If NO, skip to 2.

   a) Aspirin

      i) During the last month has the patient taken any aspirin?   (1) (2)

        If NO, skip to 1.b.
        If YES, answer the following:

        a) Was aspirin taken for:

           Pain   (1)

           Prophylactics   (2)

           Other, specify: _____ (3)

        b) Dosage:

Dosage:	81mg	227mg	325mg	400mg	500mg
Total # of Days:	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _
Total # of Tablets:	_ _ _	_ _ _	_ _ _	_ _ _	_ _ _

	No	Yes
b) Tylenol, Advil, Motrin	(1)	(2)
c) Cold medications	(1)	(2)
d) Other, specify: _____	(1)	(2)

**If the patient uses no other prescription or
non-prescription medications check here and STOP.**   **(1)**

2. Has the patient used vitamin and/or mineral supplements on a   No   Yes
   regular basis?   (1) (2)

   If YES, specify: _____

   _____

3. Has the patient used any herbal supplements on a regular basis?   (1) (2)

   If YES, specify: _____

   _____

4. Has the patient used any dietary supplements on a regular basis? (1) (2)

   If YES, specify: _____

   _____

   If the patient uses no other prescription or
   non-prescription medications, check here and STOP.   **(1)**

5. Use of prescription and/or non-prescription
   Non-Steroidal Anti-Inflammatory Medications
                                                                       No   Yes
   a) During the last month, has the patient taken any non-steroidal
      anti-inflammatory medications?   (1) (2)
      If NO, skip to 6.
      If YES, answer the following:

      i) How many days, during the last month, has the patient
         taken prescription and/or non prescription Non-Steroidal
         Anti-Inflammatory medications?   __ __ days

      ii) Which medication has the patient taken during the last month?
          (✓ all that apply)
                                                                       No   Yes
          a. Ibuprofen (e.g., Advil, Medipren, Motrin, Nuprin)   (1) (2)
          b. Naproxen (e.g., Naprosyn, Anaprox, Aleve)   (1) (2)
          c. Diclofenac   (1) (2)
          d. Nabumetone   (1) (2)
          e. Indomethacin (e.g., Indocin)   (1) (2)
          f. Etodolac   (1) (2)
          g. Piroxicam (e.g., Feldene)   (1) (2)
          h. Clinoril   (1) (2)
          i. Dolobid   (1) (2)
          j. Meclomin   (1) (2)
          k. Other, specify: _____   (1) (2)

      If the patient uses no other prescription or
      non-prescription medications, check here and STOP.   **(1)**

6. Has the patient taken any other prescription medication   No   Yes
   for pain on a regular basis?   (1) (2)
   If YES, specify Name: _____

                     Name: _____

If the patient uses no other prescription or
non-prescription medications, check here and STOP.   **(1)**

7. If the patient is **female**, ask the following:
   If NO, skip to 8.

                                                              No   Yes
   a) Has the patient used oral contraceptives since the last visit? (1)   (2)
      If YES, specify Name: _____

      If YES, how long has the patient been taking
      oral contraceptives?   __ __ years __ __months

   b) Has the patient used any other hormonal therapy   No   Yes
      for contraception?   (1)   (2)
      If YES, specify Name: _____

   c) Has the patient taken hormone replacement therapy (HRT)   (1)   (2)
      If NO, skip to 8.
      If YES, answer the following:

      i) How long has the patient taken HRT?   __ __ years __ __months

                                                         No Yes Unsure
      ii) Does this include a progestational agent?   (1)(2) (3)

   If the patient uses no other prescription or
   non-prescription medications, check here and STOP.   **(1)**

8. If the patient is male, ask the following:
   If FEMALE, skip to 9.

                                                              No   Yes
   a) Has the patient taken any medications for impotence?   (1)   (2)
      If YES, specify Name: _____

   If the patient uses no other prescription or
   non-prescription medications, check here and STOP.   **(1)**

                                                              No   Yes
9. Has the patient taken any other hormones?   (1)   (2)
    If NO, skip to 10.

    a) Thyroid   Name: _____ (1)   (2)

    b) Glucocorticoids   Name: _____ (1)   (2)

    c) Mincralcovticoids Name: _____ (1)   (2)

    d) Amylin   Name: _____ (1)   (2)

    e) Other   Name: _____ (1)   (2)

    If the patient uses no other prescription or
    non-prescription medications, check here and STOP.   **(1)**

                                                            No   Yes
10. Has the patient taken lipid lowering medications?   (1) (2)
     If YES, specify Name: _____

                    Name: _____

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

                                                            No   Yes
11. Has the patient taken anticoagulants?   (1) (2)
    If YES, specify Name: _____

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

12. Has the patient taken any of the following regularly?
                                                            No   Yes
    a) Tranquilizers: (1) (2)
       If YES, specify Name: _____

                    Name: _____
                                                            No   Yes
    b) Antidepressants: (1) (2)
       If YES, specify Name: _____

                    Name: _____

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

                                                            No   Yes
13. Has the patient taken coronary vasodilators?   (1) (2)
    If YES, specify Name: _____

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

                                                            No   Yes
14. Has the patient taken digitalis?   (1) (2)

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

                                                            No   Yes
15. Has the patient taken antiarrythmic medications?   (1) (2)
    If NO, skip to 16.

    a) Quinidine   (1) (2)

    b) Procaine amide   (1) (2)

    c) DPH (diphenylhydantoin)   (1) (2)

    d) Other, specify: _____   (1) (2)

     **If the patient uses no other prescription or
     non-prescription medications, check here and STOP.   (1)**

                                                                      No   Yes
16. Has the patient taken
    ACE (angiotensin converting enzyme) inhibitors?   (1) (2)
    If YES, specify name: _____

    If NO, skip to 17.
    If YES, does the patient take ACE inhibitors for: (✓ all that apply)

    a) Hypertension   (1) (2)

    b) Nephropathy   (1) (2)
         1) Macroalbuminuria   (1) (2)
         2) Microalbuminuria   (1) (2)

    c) Prophylactic Reasons   (1) (2)

17. Has the patient taken
    ARB (angiotensin receptor blockers) inhibitors?   (1) (2)
    If YES, specify name: _____

    If NO, skip to 18.
    If YES, does the patient take ARB inhibitors for: (✓ all that apply)

    a) Hypertension   (1) (2)

    b) Nephropathy   (1) (2)
         1) Macroalbuminuria   (1) (2)
         2) Microalbuminuria   (1) (2)

    c) Prophylactic Reasons   (1) (2)

18. Has the patient taken any antihypertensives?   (1) (2)
    If NO, skip to 19.
    If YES, answer the following.

    a) Diuretics   (1) (2)
       If YES, answer each:

        i. Hydrochlorothiazide (HydroDIURIL)   (1) (2)

       ii. Other thiazide diuretic   (1) (2)

             If YES, specify Name: _____

      iii. Furosemide (Lasix)   (1) (2)

       iv. Other loop diuretic (e.g., Bumetanide, Bumex),   (1) (2)

             If YES, specify Name: _____

        v. Other, specify Name: _____

    b) Beta blockers   (1) (2)
       If YES, specify Name: _____

    c) Calcium channel blockers (e.g. Diltiazem, Cardizem,
       Nifedipine, Procardia, Verapamil, Calan, Covera-HS, Verelan,
       Amlodipine, Norvasc, Felodipine, Plendil)   (1) (2)

d) Prazosin-like agents/alpha-blockers (e.g. Minipress, Minizide,
   Terazosin, Hytrin, Doxazosin, Cardura)   (1) (2)

e) Clonidine (Catapress)   (1) (2)

f) Minoxidil   (1) (2)

g) Labetalol (Normodyne)   (1) (2)

h) Methyldopa (Aldomet)   (1) (2)

i) Hydralazine (Apresoline, Reserpine, Serpasil)   (1) (2)

j) Guanabenz (Wytensin)   (1) (2)

k) Guanfacine (Tenex)   (1) (2)

l) Other, specify Name: _____   (1) (2)

**If the patient uses no other prescription or
non-prescription medications, check here and STOP.**   **(1)**

	Right Eye		Left Eye	
	No	Yes	No	Yes
19. Has the patient used ocular medications which require a prescription? **If NO, skip to 20. If YES, answer the following:**	(1)	(2)	(1)	(2)

	Right Eye		Left Eye	
	No	Yes	No	Yes
a) Steroid drops	(1)	(2)	(1)	(2)
b) Glaucoma drops	(1)	(2)	(1)	(2)
c) Mydriatics	(1)	(2)	(1)	(2)
d) Other (specify below)	(1)	(2)	(1)	(2)

    R- Name: _____

    L- Name: _____

20. Has the patient taken any other medication(s)   No   Yes
     not previously specified?   (1) (2)
     If YES, specify Name: _____

                    Name: _____

                    Name: _____

                    Name: _____

Type or print name of person completing form: Certification
                                                          Number

_____   __ __ - __ __