HALT-C Trial

Baseline Medications Interview

Form # 7 Version B: 12/03/2001

SECTION A: GENERAL INFORMATION

A.1. Affix ID Label Here → __ __ - __ __ __ - __

A.2. Patient initials: __ __ __

A.3. Visit number: __ __ __

A.4. Visit Date: MM / DD / YYYY __ __ / __ __ / __ __ __ __

A.5. Initials of person completing form: __ __ __ **Signature required**

This form asks about current prescribed medications (Section B), past herbal and alternative medications (Section C) and non-prescription medications (Section D)

SECTION B: CURRENT PRESCRIBED MEDICATIONS

ASK THE PATIENT ABOUT MEDICATIONS PRESCRIBED BY A DOCTOR OR NURSE PRACTITIONER. THIS INCLUDES ALL PRESCRIPTION MEDICATIONS INCLUDING PAIN AND INFLAMMATION MEDICATIONS THAT REQUIRE A PRESCRIPTION.

B1. Is the patient currently taking any medications prescribed by a doctor or nurse practitioner? YES ……1 NO …….. 2 **(SECTION C)**

B2. What prescription medications is the patient taking now?

	MEDICATION NAME	CODE
	a.	b.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

14.		

SECTION C: PAST HERBAL, ALTERNATIVE, DIETARY SUPPLEMENTS AND OTHER BOTANICAL MEDICATIONS

FOR THIS SECTION ONLY, SHOW CARD #10.

PLEASE KEEP THE CARD VISIBLE TO THE PATIENT WHILE ASKING ALL THE QUESTIONS IN THIS SECTION.

ASK THE PATIENT ABOUT HERBAL, ALTERNATIVE, DIETARY SUPPLEMENTS, AND OTHER BOTANICAL MEDICATIONS. THESE ARE OFTEN CALLED COMPLEMENTARY OR ALTERNATIVE MEDICINES.

C1. Has the patient ever taken any of these medications at least once a week for 1 month or longer?

YES 1
NO ..... 2 **(D1)**
DON'T KNOW .....-8 **(D1)**

REPEAT QUESTIONS C2a - C2d FOR EACH MEDICATION THE PATIENT TOOK AT LEAST ONCE A WEEK FOR ONE MONTH OR LONGER. AS YOU CONTINUE THE QUESTIONING FOR EACH MEDICATION, COMPLETE THE TABLE ROW BY ROW. PROBE UNTIL THERE ARE NO MORE MEDICATIONS TO REPORT.

C2.	**Which of these medications did the patient take at least once a week for 1 month or longer? (MEDICATION NAME)**	**(CODE)**	**For how many months or years, in total, has the patient taken (MEDICATION) at least once a week?**	
	a.	b.	c.	d.
1.			__ __ years	__ __ months
2.			__ __ years	__ __ months
3.			__ __ years	__ __ months
4.			__ __ years	__ __ months
5.			__ __ years	__ __ months
6.			__ __ years	__ __ months
7.			__ __ years	__ __ months
8.			__ __ years	__ __ months
9.			__ __ years	__ __ months
10.			__ __ years	__ __ months

Patient ID: ___ ___ - ___ ___ ___ - ___

SECTION D: CURRENT NON-PRESCRIPTION MEDICATIONS (HERBAL, ALTERNATIVE, OR OTHER OVER THE COUNTER)

ASK THE PATIENT ABOUT CURRENT USE OF HERBAL, ALTERNATIVE, OR OTHER OVER THE COUNTER MEDICATIONS. CONTINUE TO SHOW CARD #10. THIS INCLUDES ALL OVER THE COUNTER MEDICATIONS THAT THE PATIENT MAY BE USING FOR ANY REASON, INCLUDING TO RELIEVE PAIN OR INFLAMMATION AND INCLUDES ASPIRIN PRODUCTS THAT MAY BE TAKEN FOR HEART HEALTH REASONS.

D1. Is the patient currently taking any herbal, alternative, or over the counter or non-prescribed medicines or supplements, including those already discussed?
(Not prescribed by a doctor or nurse practitioner)

YES …… 1
NO ……. 2 **(END OF FORM)**

D2. What non-prescribed medications is the patient currently taking?

	MEDICATION NAME	CODE
	a.	b.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Signature _____