DAILY
MEDICATION DIARY
(TO KEEP AT BEDSIDE)

PATIENT INITIALS : __ __ __

RC I.D. # : __ __ __ __

DATED:

FROM: __ __ / __ __ / __ __ __ __

TO: __ __ / __ __ / __ __ __ __

WEEK # ____

ICCTG
Protocol #1

Ptdiary_version_4.0_063099

PTDIARY

Instructions for Completing the Medication Diary:

This diary is to be completed during the time period indicated by the dates listed on the front cover. Keep this diary at your bedside. Before you go to bed for the night, record the date and complete questions #1 and #2. Then, list any ***changes*** in medications or any ***new*** medications you have taken that day. Include all medications taken: both over-the-counter and prescription medications. List the strength in units and the form of each dose. List the route of the medication, then the total number of doses you took that day. If you take the drug "as needed" or if you forgot how much you took, just use your best estimate. Then complete the columns that ask whether this medication was taken for IC and whether this medication for taken for pain.

If you have any questions about completing this form, call your Research Coordinator.

Thank you for completing this diary.

Please note the following restrictions:

<u>Exclusionary Medication:</u>

You *cannot* take cimetidine (Tagamet®) *at any time* while participating in this study.

<u>Restricted Medications:</u>

Check with your Research Coordinator before taking the following products (SOME examples are listed)

- ASPIRIN PRODUCTS

  (Anacin®, Bayer®, Bufferin®, Ecotrin®, Excedrin®)

- ASPIRIN REPLACEMENT PRODUCTS

  (Acetaminophen, Actron®, Advil®, Aleve®, Feldene®, Indocin®, Midol®, Motrin®, Relafen®, Tylenol®)

- DIPHENDYDRAMINE, BROMPHENIRAMINE, OR CHLORPHENIRAMINE

  (Dimetane®, Allerest®, Contact®, Sudafed®, Excedrin P.M.®, Unison®)

Date: ___ ___ / ___ ___ / ___ ___
month day year

1. **Number of *White* pills taken today:** _____

2. **Number of *Green* pills taken today:** _____

Before you go to sleep, please list all new medications or changes in *over-the-counter* and *prescription* medications taken today.

Example: RC to complete with participant:					
NAME OF MEDICATION:	**STRENGTH and FORM** (mg, ml, tablet*, capsule, teaspoon, tablespoon, IU, drops, cream, spray, other) **PER DOSE:**	**ROUTE:** (oral, injection, skin, rectal, nasal, patch, inhalant, intravesical**, other)	**TOTAL NUMBER OF DOSES PER 24 HOURS: (or estimate, if necessary)**	**Are you taking this medication for pain?** Yes / No	**Are you taking this medication for your IC?** Yes / No

*includes caplets, gelcaps

**instilled into the urinary bladder