Concomitant Medications Form

tblPConcomMed & tblPConcomMedDetail

Complete One Form for Each Medication

tblPtRoster.PtID	**PtID:** _____
tblPtRoster.Namecode	**Namecode:**_____

ParentDrugListID	**1. Medication Name:** _____
MedDose **MedUnit** **MedDoseUNK**	**2. Dose per administration (include unit):** **Dose:** _____ **Unit:** _____ **or** ☐ **Unknown**
MedRoute	**3. Route:** ☐ S.C.-subcutaneous ☐ I.V.-intravenous ☐ Gtt-drops ☐ I.D.-intradermal ☐ I.M.-intramuscular ☐Topical ☐ P.O.-by mouth ☐ P.R.-by rectum ☐Sublingual ☐Vaginal ☐ Intravitreal ☐ Peribulbar ☐Oral Inhalation ☐Intra-articular ☐Transdermal ☐Nasal
MedFreqNum **MedFreqPeriod** **MedFreqOne** **MedFreqUNK** **MedFreqSame** **MedFreqSameDs**	**4. Frequency:** _____ (1-50) per _____ (day, week, month, year) ☐ **One time treatment** ☐ **Unknown** **4a. Same dose consistent (e.g. sane dose everyday)?** ☐ Yes ☐ No **If 'No',** **explain:**_____ _____ _____
MedIndication	**5. Indication:** ☐ Treatment of diabetes ☐ Pre-existing condition ☐Treatment for an Adverse Event ☐ Prevention ☐ Adverse Event indicated on Injection Form
PreExistSystem	**5a. If 'Pre-existing condition', select system:** *(Note: If a pre-existing condition is not listed; select finish later below, add the condition to the patients Pre-Existing Condition Form, and reopen this medication form.)* ☐ Hypertension ☐Elevated Cholesterol ☐ENT ☐Cardiovascular ☐ Respiratory ☐Gastrointestinal ☐Renal (Kidney) ☐Genitourinary ☐Hepatic (Liver) ☐Endocrine ☐Neurological ☐Musculosketal ☐Skin ☐Psychological ☐Blood/Lymphatic ☐ Allergy ☐Other: _____
ParentLogInIDAdvEvent	**5b. If 'Treatment for Adverse Event' list all AE's for patient**: _____ _____ _____

MedStartDt

6. Start Date: If < 30 days, enter date:

☐ **Today If not today, enter date:**

___ ___ / ___ ___ ___ / ___ ___ ___ ___ *MMM/dd/yyyy*

MedStartCat

If >30 days, select date range: ☐ >30 days ago to 3 months ago
☐ >3 months ago to 6 months ago
☐ >6 months ago to 1 year ago
☐ >5 years ago to 10 years ago
☐ >10 years ago

(Post-enrollment: Only complete, if medication started prior to enrollment):

MedStopDt

7. Stop Date *(or mark box if ongoing)***:**

☐ **Today If not today, enter date:**

___ ___ / ___ ___ ___ / ___ ___ ___ ___ *MMM/dd/yyyy*

MedOngoing

☐ **Ongoing**

FormCmts

Comments_____

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