F303: Baseline Medication Audit, version 03/27/06 (A)_rev04/06/06

UITN
TOMUS

SECTION A: GENERAL STUDY INFORMATION FOR OFFICE USE ONLY:

A1. STUDY ID#: LABEL

A2. VISIT # BASELINE.....TBAS

A3. DATE AUDIT COMPLETED: ___ ___ / ___ ___ / ___ ___ ___ ___

A4. INTERVIEWER INITIALS: ____ ____ ____

A5. IS THIS A REPEAT MEASURE DUE TO A PREVIOUSLY EXPIRED MEASURE?

YES..... 1

NO 2

SECTION B: MEDICATION AUDIT

B1. Are you currently taking any medication **prescribed** by a medical doctor, nurse practitioner or physician's assistant?

YES 1

NO..... 2 ➔ **SKIP TO B3**

B2. RECORD EACH PRESCRIPTION MEDICATION BY NAME.

I need to get a record of all your prescribed medications. Let's go through them one by one. (**PROBES:** Think about hormones, steroids, antibiotics, pain medications, as well as medications that you take for your urinary incontinence. Think about any pills that you take by mouth, or liquids that you drink. Think about aerosols that you inhale, patches that you place on your skin, or medicines you inject with a syringe. Think about suppositories, vaginal creams or a vaginal ring, drops for your eyes or ears or nasal sprays. Skin creams or salves should also be included. Some prescribed medications like aspirin are actually available without a prescription but I will list them here if a doctor or nurse prescribed them.)

†**SOURCE CODES**: 1 = PATIENT ONLY; 3 = BOTH PATIENT AND RECORD, 5 = PT REPORT AND SENT FOR MR

	a.	b.	c.	e.	f.
	MEDICATION NAME (PRINT NAME PRECISELY)	**FREQUENCY**	**START DATE**	**TAKEN FOR INCONTINENCE?**	**SOURCE CODE†**
1.		REGULARLY ..... 1 PRN .....2 RX'D / NOT USED..... 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES .....1 NO.....2	_____
2.		REGULARLY ..... 1 PRN .....2 RX'D / NOT USED..... 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES .....1 NO.....2	_____
3.		REGULARLY ..... 1 PRN .....2 RX'D / NOT USED..... 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES .....1 NO.....2	_____
4.		REGULARLY ..... 1 PRN .....2 RX'D / NOT USED..... 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES .....1 NO.....2	_____

Affix ID Label Here

†**SOURCE CODES**: 1 = PATIENT ONLY; 3 = BOTH PATIENT AND RECORD, 5 = PT REPORT AND SENT FOR MR

	a.	b.	c.	e.	f.
	MEDICATION NAME (PRINT NAME PRECISELY)	**FREQUENCY**	**START DATE**	**TAKEN FOR INCONTINENCE?**	**SOURCE CODE†**
5.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____
6.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____
7.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____
8.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____
9.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____
10.		REGULARLY ..... 1 PRN ..... 2 RX'D / NOT USED .. 3	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR	YES..... 1 NO..... 2	_____

B3. Are you currently taking any medications, supplements, or vitamins **not prescribed** by a physician, NP, or PA?

YES..... 1

NO..... 2 (**END)**

B4. **RECORD ALL OVER-THE COUNTER AND / OR SELF-PRESCRIBED MEDICATIONS. ASK:**

I need to get a record of all of these too. Let's go through them one by one. (**PROBE**: This includes medication that you take on your own for any reason, including vitamins and supplements or medications you might take for pain relief or inflammation. This also includes any medications that you might take on the advice of someone else.)

	a.	b.	c.
	MEDICATION NAME (PRINT NAME PRECISELY)	**FREQUENCY**	**START DATE**
1.		REGULARLY ..... 1 PRN 2	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR
2.		REGULARLY ..... 1 PRN 2	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR
3.		REGULARLY ..... 1 PRN 2	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR
4.		REGULARLY ..... 1 PRN 2	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR
5.		REGULARLY ..... 1 PRN 2	__ __ / __ __ / __ __ __ __ MONTH DAY YEAR