COMMENTS	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name ______________________M.I.______ Last Name ________________________________

1. Date of Contact: └─┴─┘-└─┴─┘-└─┴─┘ (M/D/Y)
2. Staff ID: └─┴─┴─┘ _______________
3. Contact Type:
   - ☐1 Phone
   - ☐2 Mail
   - ☐3 Visit
   - ☐8 Other
4. Visit Type:
   - ☐1 Screening # └─┘
   - ☐2 Semi-Annual # └─┴─┘
   - ☐3 Annual # └─┴─┘
   - ☐4 Non-Routine

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5. Label Product Name ______________________________________
6. Label Generic Name ______________________________________
7. Dosage Form (tablet, cream, suppository, etc.) ____________________________
8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)
9. Duration └─┴─┴─┘ 10. UOM _________

UOM	
D = Day	M = Month
W = Week	Y = Year

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

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5. Label Product Name ______________________________________
6. Label Generic Name ______________________________________
7. Dosage Form (tablet, cream, suppository, etc.) ____________________________
8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)
9. Duration └─┴─┴─┘ 10. UOM _________

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9. Duration └─┴─┴─┘ 10. UOM _________

UOM	
D = Day	M = Month
W = Week	Y = Year

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

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K ________

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6. Label Generic Name ______________________________

7. Dosage Form (tablet, cream, suppository, etc.) ______________________

8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)

9. Duration |__|__|__| 10. UOM _________

UOM
D = Day M = Month
W = Week Y = Year

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

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6. Label Generic Name ______________________________

7. Dosage Form (tablet, cream, suppository, etc.) ______________________

8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)

9. Duration |__|__|__| 10. UOM _________

UOM
D = Day M = Month
W = Week Y = Year

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

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K ________

Aspirin

A. **"Do you take aspirin pills or powders, for example, Anacin, Bufferin, BC? This does not include aspirin-free drugs such as Tylenol or Advil."**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, powder, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Acetaminophen

B. **"Do you take Acetaminophen tablets, or capsules, for example, Tylenol:"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Ibuprofen

C. **"Do you take Ibuprofen tablets or capsules, for example, Advil, Motrin, or Nuprin?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Other anti-inflammatory pain pills ****Note: Most of these are prescription drugs****

D. **"Do you take Naprosyn, Naproxen, Aleve, Indocin, Clinoril, Feldene, or other anti-inflammatory pain pills?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

K _____

Cold and Allergy Medications

E. **"Do you take anything for colds or allergies, for example, Dristan, Sudafed, Actifed, Dimetapp, Benadryl, Seldane, or Tavist D?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, syrup, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Laxatives

F. **"Do you take bulk laxatives or fiber-containing medications such as Metamucil, Fiber-eze, Citrucel, Senokot, Ex-Lax, or stool softeners such as Colace or DOSS, or any other medications for laxative purposes?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, liquid, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Digestive Aids

G. **"Do you use any medications to help you with digestion, such as Mylanta, Tums, DiGel, Alka-Seltzer, Pepcid AC, or Pepto-bismol?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, suspension, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Herbal Estrogens

H. **"Do you use any herbal estrogens, natural female hormones, or phytoestrogens, such as dong quai or black cohosh?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, suspension, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

K _____