Form 153 – Medication and Supplement Inventory
WHI Extension Study

Date Received: ☐☐-☐☐-☐☐ (MM/DD/YY) Reviewed By: ☐☐-☐☐☐		**- Affix label here-** Participant ID: __ __ __ __ - ___ ___ ___ - ___ First Name _____M.I._____ Last Name _____
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OFFICE USE ONLY		

Instructions:

To help us learn about the health of WHI participants, we would like to know about the medications and supplements you take.

This form asks about all of the prescription medications you are currently taking, and some of the over-the-counter medications and dietary supplements you may be taking.

If you would like to have a WHI staff member at the Clinical Coordinating Center complete this form with you over the phone, please feel free to call 1-800-218-8415.

Section A: Prescription Medications

This first section asks about **prescription medications** you are currently taking. This includes medications that you only take as needed, such as nitroglycerin. A prescription medication is one that is written (or phoned in) by your health care provider and must be filled at a pharmacy or drug store.

1. **Are you currently taking any medications that require a prescription from a doctor or health care provider**?

   ☐ 0 No → **Go to Section B on Page 6**

   ☐ 1 Yes → **Continue below**

For this section, you will need information from the labels on bottles or packaging that your prescription medications came in. To get started, please gather together all of your prescription medications so that this information is readily available as you complete the form. These medications may be in your medicine cabinet, refrigerator, or purse. It is important to include all of your prescriptions.

For each prescription medication, please answer the questions on the next page, including the medication's name and strength. You will find this information on the label of the pill bottle or container. An example of a prescription label and a completed medication question are shown below.

Example of a prescription label

Walgreens, Seattle, WA 98028
(DD/) Ph: 866-254-1669
RX#4599773 Sept. 6, 2005 Fill 1 of 1

DOE, JANE 206-566-0442
Take one capsule by mouth as directed in morning and at bedtime
Discard after Sept. 6, 2006 Mfr_____
Qty: 60 CAP Kroll, Phil MD
Phenytoin NA (Dilantin) 100 MG CAP

On the example prescription label, the medication name **Phenytoin NA (Dilantin)**, strength **100 MG**, and type **CAP** are all on one line.

Example of a completed question using the label example above

Prescription Medication	Write in Information Below:
Name of the medication (as written on label)	PHENYTOIN NA (DILANTIN)
Strength of the medication (as written on label)	100 MG
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	CAPSULE
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ■ 3 More than 1 year → **How many years?** 013

Please go to next page

2. For each of the prescription medications you are currently taking, please answer the questions below **using the label on the prescription bottle**. Please **print** clearly. You can use your best estimate about how long you have been taking the medication.

Complete all of the information in the table for *each* medication you take. There are enough boxes to write up to 10 different medications. When you have completed the information for all of your prescription medications, please go to **Section B** of the questionnaire on **page 6.**

Prescription Medication #1	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #2	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #3	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Continue on the next page, <u>or</u> go to Section B on page 6 if you have listed all your medications

Prescription Medication #4	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #5	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #6	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #7	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #8	**Write in Information Below**:
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #9	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #10	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Continue on the next page, or go to Section B on page 6 if you have listed all your medications

3. In the previous question there was room to write up to 10 prescription medications. If you take more than 10, please list the names of those medications below. List only their names, and do not include any medications you already told us about in the prescription medications table. You may receive a call from the WHI Clinical Coordinating Center to gather more detailed information on these medications. If you do not take more then 10, skip to question 4.

a._____ f. _____

b._____ g. _____

c. _____ h. _____

d. _____ i. _____

e. _____ j. _____

Section B: Barriers to Prescription Medications

4. Have any of the following barriers prevented you from obtaining or taking any medications that have been prescribed for you? **(Please check all that apply.)**

- ☐ 1 My health insurance would not cover the medication.
- ☐ 2 The medication or copayment cost too much.
- ☐ 3 It is a problem for me to get to the medical facility/physician.
- ☐ 4 Taking the medication would be inconvenient.
- ☐ 5 I was concerned about possible side effects or complications from the medication.
- ☐ 6 I was concerned about missing work due to taking the medication.
- ☐ 7 My family discouraged me from taking the medication.
- ☐ 8 My friends discouraged me from taking the medication.
- ☐ 9 I am taking too many medications.
- ☐ 10 I don't like taking medications.
- ☐ 0 I have not experienced any barriers to taking prescription medications.

Please go to next page

Section C: Non-Prescription Medications

The next set of questions ask about certain **non-prescription medicines** you have taken **at least once a week in the past two weeks**. These are medicines that you can buy **over-the-counter without a prescription** from your health care provider.

5. **Please answer the following questions about the non-prescription medicines listed below.** For each type of medicine that you are taking, please write in the name and strength from the product label, how often you take it, and how long you have taken it. **For some types listed below, there is space to write in two products. If you are taking more than two, please write in just the two products that you take most often.** Note that the brand names provided below are just examples; write in the brand of the medicine you are taking.

5.1 Are you taking Aspirin, for example, Bayer, St. Josephs, Bufferin, Anacin, Excedrin, BC powder, baby aspirin, Doan's? (This does not include aspirin-free drugs such as Tylenol or Advil.)

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.2 Are you taking Anti-Inflammatory pain medicines, such as Advil, Aleve, Ibuprofen, Motrin, Naprosyn, Naproxen, Nuprin, Anaprox, or Orudis KT?

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

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5.3 Are you taking a second type of Anti-Inflammatory pain medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.4 Are you taking an Antacid or heartburn medicine, such as Axid, Pepcid AC, Prilosec, Tagamet, Zantac, Cimetidine, Famotidine, Omeprazole, or Ranitidine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.5 Are you taking a second type of Antacid or heartburn medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

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5.6 Are you taking natural female hormones, herbal estrogens, or phytoestrogens, such as Remifemin, DHEA pills, wild yam, soy or flax products, dong quai, or black cohosh?

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

5.7 Are you taking a second type of natural female hormones, herbal estrogens, or phytoestrogens?

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

6. In most states, some types of insulin can be purchased over-the-counter without a prescription. If you are currently taking insulin and you haven't included it on the list of your prescription medicines in Section A, please write it in question 6.1 below.

6.1 Are you taking <u>over-the-counter insulin</u>? If you listed insulin as a prescription medication in Section A, do not include it again here.

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 Less than once a day	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

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Section D: Dietary Supplements

In this final section, we ask about certain **vitamin or mineral supplements** you have taken **at least once a week in the past two weeks.**

7. Please answer the following questions about the **vitamin or mineral supplements** listed below. For each vitamin supplement that you are taking, please write in the name from the bottle/package, how often, and how long you have been taking it. Although you may be taking other supplements at this time, we are asking only for information on the supplements listed.

7.1 Are you taking a Daily Multi-Vitamin Supplement that has 10 or more vitamins and/or minerals in one pill? Examples are One-A-Day, Centrum, Theragran, Geritol.

☐ 1 Yes → / ☐ 0 No ↓	**Product name and/or brand** (listed on the bottle)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.2 Are you taking Calcium/Vitamin D supplement mixture? This is a pill that contains both Calcium and Vitamin D, but not in a multi-vitamin with several vitamins and minerals.

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Calcium Strength:** _____ **Vitamin D Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

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7.3 Are you taking Calcium as a single mineral supplement containing no other vitamins or minerals?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.4 Are you taking Vitamin D (Calciferol) as a single vitamin supplement containing no other vitamin or mineral?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

8. What is the date that you completed this form? ⌊__⌋-⌊__⌋-⌊__⌋
Month Day Year

Thank you.
Please take a moment to review
any questions you may have missed.