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| COMMENTS | <p>- Affix label here-</p> <p>Clinical Center/ID: _____ - _____ - _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p> |
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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

-
5. Label Product Name _____
6. Label Generic Name _____
7. Dosage Form (tablet, cream, suppository, etc.) _____
8. Strength _____ mg _____ % _____ Other (Specify: _____)
- UOM**
9. Duration 10. UOM _____
D = Day M = Month
W = Week Y = Year
11. If corticosteroid, taken orally and daily? ___ Yes ___ No

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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 _____

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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 _____

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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 _____

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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 _____

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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 _____

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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 _____

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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 _____

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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: _____)

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K _____

