



# SLEEP HEART HEALTH STUDY

MEDICATIONS - PRESCRIPTION  
AND OVER-THE-COUNTER

ID#: \_\_\_\_\_

Field Center: \_\_\_\_\_

## Section A Medication Reception

As you know, the Sleep Heart Health Study will be describing all medications its participants are using, both prescription and over-the-counter. These include pills, dermal patches, eye drops, creams, salves, and injections, as well as vitamins, cold or allergy remedies, aspirin, and Tylenol. Are these all the medications that you took in the last two weeks?

yes  1 **May I see them?**  
 no  0 *Make arrangements to obtain*  
 took no medicines  2 **Go to Section C**  
 refused  9  
 ↓

Reasons for refusal: \_\_\_\_\_

**Go to Section C**

## Section B Prescription Medications

1 Copy the name of the medicine, the strength in milligrams (mg) and the total number of doses prescribed per day week or month. (Include pills, dermal patches, eye drops, creams, salves, and injections.)

2 On the average during the last two weeks, how many of these pills did you take a day (or week/month)?

	Medication Name <i>Print the first 20 letters only--please print clearly.</i>	Strength (mg) <i>Write the decimal as one of the digits.</i>	Number Prescribed <i>Circle: day, week, or month</i>	PRN Medicine?	
1			___ D W M	Y N	___ D W M
2			___ D W M	Y N	___ D W M
3			___ D W M	Y N	___ D W M
4			___ D W M	Y N	___ D W M
5			___ D W M	Y N	___ D W M
6			___ D W M	Y N	___ D W M
7			___ D W M	Y N	___ D W M
8			___ D W M	Y N	___ D W M
9			___ D W M	Y N	___ D W M
10			___ D W M	Y N	___ D W M
11			___ D W M	Y N	___ D W M
12			___ D W M	Y N	___ D W M
13			___ D W M	Y N	___ D W M
14			___ D W M	Y N	___ D W M
15			___ D W M	Y N	___ D W M

Number unable to transcribe: \_\_\_\_\_

