HEALTH ●

DY

MEDICATIONS

Field Site ID: CLINIC

Participant ID#: PPTID

Alpha Code: SHHS __ __ __

Date form initiated: FORMDATE __ __ − 2 0 0 __
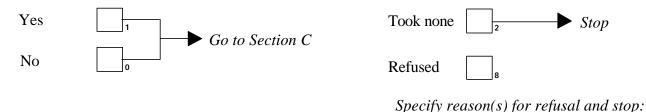month   day   year

Visit ID Code: F 0 2

Form & revision: M D 2

Form sequence: FORMSEQ

A. Medication Retrieval

"As you know, the Sleep Heart Health Study will be describing all prescription and non-prescription medications its participants are using. These include pills, skin patches, eye drops, creams, salves, and injections, as well as vitamins, cold or allergy remedies, aspirin, and Tylenol. Please show me all your medications." *(When medications are assembled)* "Are these all the medications that you took in the last two weeks?"

Yes [ ]₁
No [ ]₀ → *Go to Section C*

Took none [ ]₂ → *Stop*
Refused [ ]₈

Specify reason(s) for refusal and stop:

_____

B. Number of Medications

*Instructions: If no PSG done, complete items **a-d** after completing Section C. If PSG done, complete items **a** and **b**, then complete items **c** and **d** after NM form collected.*

a. Number of prescription and non-prescription medications able to transcribe: ___ ___

b. Number of medications unable to transcribe: ___ ___

c. Number of night medications added: ___ ___

d. Total number of medications for data entry: ___ ___

C. Prescription medications (if no prescription medications were taken, go to Section D.)

(Include pills, skin patches, eye drops, creams, salves, and injections.)

a. Medication name (first 20 characters only)	b. Dose Strength prescribed (Units: mg, mL, %, etc.)	c. Number of pills or unit doses prescribed per day, week, or month (circle D,W, or M)	d. Check if PRN	e. Average # of pills or unit doses used per day, week, or month in last 2 weeks (circle D,W, or M)	f. Check if used today	(Fill in after NM form collected) g. Check if used according to NM form
1. __	_____	___ D W M	☐	___ D W M	☐	☐
2. __	_____	___ D W M	☐	___ D W M	☐	☐
3. __	_____	___ D W M	☐	___ D W M	☐	☐
4. __	_____	___ D W M	☐	___ D W M	☐	☐
5. __	_____	___ D W M	☐	___ D W M	☐	☐
6. __	_____	___ D W M	☐	___ D W M	☐	☐
7. __	_____	___ D W M	☐	___ D W M	☐	☐
8. __	_____	___ D W M	☐	___ D W M	☐	☐
9. __	_____	___ D W M	☐	___ D W M	☐	☐
10. __	_____	___ D W M	☐	___ D W M	☐	☐
11. __	_____	___ D W M	☐	___ D W M	☐	☐
12. __	_____	___ D W M	☐	___ D W M	☐	☐
13. __	_____	___ D W M	☐	___ D W M	☐	☐
14. __	_____	___ D W M	☐	___ D W M	☐	☐
15. __	_____	___ D W M	☐	___ D W M	☐	☐

D. Non-Prescription medications (if no non-prescription medications were taken, stop)

(Include pills, skin patches, eye drops, creams, salves, and injections.)

	a. Medication name (first 20 characters only)	**b.** Dose — Strength prescribed (Units: mg, mL, %, etc.)	**c.** Average # of pills or unit doses used per day, week, or month in last 2 weeks *(circle D,W, or M)*	**d.** Check if used today	*(Fill in after NM form collected)* **e.** Check if used according to NM form
16.	_____	_____	___ D W M	☐	☐
17.	_____	_____	___ D W M	☐	☐
18.	_____	_____	___ D W M	☐	☐
19.	_____	_____	___ D W M	☐	☐
20.	_____	_____	___ D W M	☐	☐
21.	_____	_____	___ D W M	☐	☐
22.	_____	_____	___ D W M	☐	☐
23.	_____	_____	___ D W M	☐	☐
24.	_____	_____	___ D W M	☐	☐
25.	_____	_____	___ D W M	☐	☐
26.	_____	_____	___ D W M	☐	☐
27.	_____	_____	___ D W M	☐	☐
28.	_____	_____	___ D W M	☐	☐
29.	_____	_____	___ D W M	☐	☐
30.	_____	_____	___ D W M	☐	☐

Comments:

_____

_____

_____

_____

Complete Section B according to instructions listed in Section B.