ARIC   **MEDICATION SURVEY FORM**

ID NUMBER: ☐☐☐☐☐☐☐   FORM CODE: | M | S | R | DATE: 09/18/2017
Version 3.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐ / ☐☐ / ☐☐☐☐   0b. Staff ID: ☐☐☐
    Month   Day   Year

A. Reception

"As you know, ARIC is recording all prescription and over-the-counter medications used by participants in the past four weeks, including cold and allergy medications, vitamins, herbal remedies, and other supplements. These medications include solid and non-solid formulations that you may swallow, inhale, apply to the skin or hair, inject, implant, or place in the ears, eyes, nose, mouth, or any other part of the body. The letter you received about this appointment included a plastic bag for all your current medications and asked you to bring them to the clinic."

1. Did you bring all the medications that you used in the past four weeks, or their containers?
   Yes, all of them .... ☐ → **GO TO SECTION B, ITEM 5**
   No, some of them .... ☐ → **GO TO SECTION A, ITEM 3**
   No, none of them .... ☐

2. Is this because you forgot, because you have not taken any medications at all in the last four weeks, or because you could not bring your medications?
   Took no medication..................................... ☐ → **End Form**
   Forgot or was unable to bring medication .... ☐ → **GO TO SECTION C, ITEM 33**

"That's all right. Since the information on medications is so important, we would still like to ask you about it during the interview."

3. May we follow up on this after the visit so that we can get the information from the other medication labels? *(Explain follow-up options)*

   Yes........................... ☐
   No or not applicable .. ☐ → *Scan/transcribe what you can in Section B. Attempt to convert Refusals. Indicate this on tracking form.*

4. Describe method of follow-up to be used:_____

B. Medication Record

Copy the MEDICATION UPC / NDC from each medication label. For each medication, begin with the left most space in fields a-c and the rightmost space in field d. Using upper case letters, carefully copy the MEDICATION NAME. Using periods to indicate decimal points, copy the formulation STRENGTH (weight for solids and concentration for nonsolids). Using upper case letters and standard abbreviations, copy the UNITS used to measure strength. For combination medications, use a forward slash (/) to separate active ingredients, corresponding strengths, and units.

#	(b) Medication UPC / NDC	Medication name (a)
5.	(c) Strength (d) Units	
6.	(c) Strength (d) Units	
7.	(c) Strength (d) Units	
8.	(c) Strength (d) Units	
9.	(c) Strength (d) Units	
10.	(c) Strength (d) Units	
11.	(c) Strength (d) Units	
12.	(c) Strength (d) Units	
13.	(c) Strength (d) Units	
14.	(c) Strength (d) Units	

#	(b) Medication UPC	Medication name (a)
15.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
16.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
17.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
18.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
19.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
20.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
21.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
22.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
23.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
24.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	
25.	□□□□□□□□□□□□	
	(c) Strength / (d) Units	

#	(b) Medication UPC	Medication name (a)
26.	☐☐☐☐☐☐☐☐☐☐☐☐	
	(c) Strength / (d) Units	
27.	☐☐☐☐☐☐☐☐☐☐☐☐	
	(c) Strength / (d) Units	
28.	☐☐☐☐☐☐☐☐☐☐☐☐	
	(c) Strength / (d) Units	
29.	☐☐☐☐☐☐☐☐☐☐☐☐	
	(c) Strength / (d) Units	

30. Total number of medications in bag .... ☐☐

31. Number of medications in bag unable to successfully scan or transcribe .... ☐☐

32. Staff ID number of person scanning / transcribing medications

a. Scanner / transcriber (items 5-29): .... ☐☐☐

b. Date of scanning / transcription: .... ☐☐ / ☐☐ / ☐☐☐☐
Month   Day   Year

C. Medication Use Interview

"Now I would like to ask about a few specific medications."

33. Were any of the medications you took during the last four weeks for: *(If "Yes", verify that the medication NAME is on the medication record.)*

	Yes	No	Unknown
a. Asthma	☐	☐	☐
b. Chronic bronchitis or emphysema	☐	☐	☐
c. High blood sugar or diabetes	☐	☐	☐
d. High blood pressure or hypertension	☐	☐	☐
e. High blood cholesterol	☐	☐	☐
f. Chest pain or angina	☐	☐	☐
g. Abnormal heart rhythm	☐	☐	☐
h. Heart failure	☐	☐	☐
i. Blood thinning	☐	☐	☐
j. Stroke	☐	☐	☐
k. Mini-stroke or TIA	☐	☐	☐
l. Leg pain while walking or claudication	☐	☐	☐