**PhenX Measure: Medication Inventory (#140300)**
**PhenX Protocol: Medication Inventory (#140301)**

Date of Interview/Examination (MM/DD/YYYY): _____

**Medication Reception**

As you know, the XX Study will be describing all medications its participants are using, both prescription and over-the-counter. These include pills, liquid medications; skin patches, eye drops, creams, salves, inhalers and injections, as well as cold or allergy medications, vitamins, herbal remedies and other supplements. The letter you received about this appointment included a plastic medications bag for all your current medications and asked you to bring them to the clinic. Have you brought this bag with you? Are these all the medications that you have taken in the past two weeks?

[ ] **Yes** → May I see them? *Continue with Section B*

[ ] **No** → *Make arrangements to obtain*

[ ] **Refused** → Record reason for refusal in Comments Section

[ ] **Took No MEDICINES** → Go to end of form

**Prescription Medications**

**1**. *Copy the name of the medicine, the strength **(include units)**, and the total number of doses prescribed per day/week/month. Include all pills, skin patches, eye drops, creams, salves, and injections.*

| **Medication Name** *Print the first 20 letters only-Please print clearly* | **Strength (mg, IU, etc.)** *Write the decimal one of the digits* | **Number Prescribed** *Circle: Day, Week, Month* | **PRN Medicine?** | On the average during the last two weeks, how many of these pills did you take a day/week/month |
|---|---|---|---|---|
| 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:[ ][ ]

**Over-the-Counter Medications**

**3**. *Copy the name of the medicine, the strength **(include units)**, and the total number of doses prescribed per day/week/month. Include all pills, skin patches, eye drops, creams, salves, and injections.*

| **Medication Name** *Print the first 20 letters only-Please print clearly* | **Strength (mg, IU, etc.)** *Write the decimal as one of the digits* | **Number Prescribed** *Circle: Day, Week, Month* | **PRN Medicine?** | On the average during the last two weeks, how many of these pills did you take a day/week/month |
|---|---|---|---|---|
| 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:[ ][ ]

Comments:

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