LONG LIFE FAMILY STUDY

(Affix Label Here)

Participant ID: _____

Participant Name Code: _____

Date Form Filled Out:

☐☐☐☐☐☐☐☐☐☐

d d M M M y y y y

(e.g., 10JUN2005)

Interviewer Code: ☐☐☐

Circle Field Center Location:

BU CU DK UP

Medication Inventory (Phase II Follow-Up)

Please Mark the Appropriate Box Below:

☐[1] .....This Form was Administered via a DFR/Proxy
☐[2] .....This Form was Administered via Telephone by Study Personnel
☐[3] .....This Form was Mailed and Self-Administered by Participant

Section A - Medication Reception

Record on the Medication Inventory Form all prescription and over-the-counter medications (including pills, dermal patches, eye drops, creams, salves, and injections) used in the previous two weeks. If possible, record the complete drug name exactly as written on the container label. Confirm strength and units.

"We are interested in all the prescription and over-the-counter medications that you took during the past 2 weeks. We are also interested in drugs not usually prescribed by a doctor, such as supplements, vitamins, pain medications, laxatives or bowel medicines, cold and cough medications, antacids or stomach medicines, and ointments or salves. Please tell me about any other medications, prescribed by a doctor, that you have not brought with you today."

Did the participant take any prescription or non-prescription medications in the past 2 weeks?

☐[1] .....Yes
☐[0] .....No
☐[D] .....Don't Know
☐[R] .....Refused

Section B - Prescription Medication and/or Over-the-Counter Medications & Supplements
Copy the name of the prescription medication and the strength in milligrams (mg) or other units. Multivitamins and herbal preparations should be coded as "N". In addition, record the formulation code.

Formulation Codes *- 0=unidentifiable, 1=oral tablet, 2=oral capsule, 3=oral liquid, 4=oral chew, 5=topical cream, lotion, or ointment, 6=other liquid, 7=ophthalmic, 8=rectal or vaginal, 9=inhaled or nasal, 10=injected, 11=transdermal patch, 12=powder, 13=other, D=missing*

Please turn to the Medication Inventory Forms on Pages 2-3

Participant ID: _____ **Participant Name Code:** _____

	Medication Name (Generic Name or Trade Name)	Strength	Units	Formulation Code	Container Seen? Yes or No	Other Notes
1.					Y N	
2.					Y N	
3.					Y N	
4.					Y N	
5.					Y N	
6.					Y N	
7.					Y N	
8.					Y N	
9.					Y N	
10.					Y N	
11.					Y N	
12.					Y N	
13.					Y N	
14.					Y N	
15.					Y N	
16.					Y N	
17.					Y N	
18.					Y N	
19.					Y N	
20.					Y N	
21.					Y N	
22.					Y N	
23.					Y N	
24.					Y N	
25.					Y N	

Participant ID: _____ **Participant Name Code:** _____

	Medication Name (Generic Name or Trade Name)	Strength	Units	Formulation Code	Container Seen? Yes or No	Other Notes
26.					Y N	
27.					Y N	
28.					Y N	
29.					Y N	
30.					Y N	
31.					Y N	
32.					Y N	
33.					Y N	
34.					Y N	
35.					Y N	
36.					Y N	
37.					Y N	
38.					Y N	
39.					Y N	
40.					Y N	
41.					Y N	
42.					Y N	
43.					Y N	
44.					Y N	
45.					Y N	
46.					Y N	
47.					Y N	
48.					Y N	
49.					Y N	

Interviewer: Attach Additional Pages As Needed