OMB#: 0925-XXXX
Exp. XX/XXXX

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OMB#: 0925-XXXX
Exp. XX/XXXX

HCHS/SOL Medication Use Questionnaire

ID NUMBER:									FORM CODE: MUE VERSION: A 7/02/07	Contact Occasion		SEQ #	

Acrostic: _____

ADMINISTRATIVE INFORMATION

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

Instructions: This form should be completed during the participant's visit. Affix the participant ID label above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "=". Code the correct entry clearly above the incorrect entry.

A. Reception

As you know, HCHS/SOL 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 1 ☐ → **GO TO SECTION B, QUESTION 5**
No, some of them 2 ☐ → **GO TO SECTION A, QUESTION 3**
No, none of them 3 ☐

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 1 ☐ → **GO TO SECTION C, QUESTION 34**
Forgot or was unable to bring medication 2 ☐

That's alright. 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)*

No or not applicable…0 ☐ → **Scan/transcribe what you can in Section B and attempt to convert refusals; indicate this on tracking form**

Yes.....1 ☐

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 non-solids). 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.

#	(a) Medication UPC / NDC		Medication name (b)
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	

#	(a) Medication UPC		Medication name (b)
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	

#	(a) Medication UPC		Medication name (b)
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 unable to scan or transcribe.....□□

32. HCHS/SOL ID number(s) of person scanning / transcribing medications and interviewing the participant:

a. Scanner / transcriber:.....□□□

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.)*

	No	Yes	Unknown
a. Asthma	0 ☐	1 ☐	9 ☐
b. Chronic bronchitis or emphysema	0 ☐	1 ☐	9 ☐
c. High blood sugar or diabetes	0 ☐	1 ☐	9 ☐
d. High blood pressure or hypertension	0 ☐	1 ☐	9 ☐
e. High blood cholesterol	0 ☐	1 ☐	9 ☐
f. Chest pain or angina	0 ☐	1 ☐	9 ☐
g. Abnormal heart rhythm	0 ☐	1 ☐	9 ☐
h. Heart failure	0 ☐	1 ☐	9 ☐
i. Blood thinning	0 ☐	1 ☐	9 ☐
j. Stroke	0 ☐	1 ☐	9 ☐
k. Mini-stroke or TIA	0 ☐	1 ☐	9 ☐
l. Leg pain while walking or claudication	0 ☐	1 ☐	9 ☐

34. During the last four weeks, did you take any aspirin or aspirin-containing products including Alka-Seltzer, cold and allergy medication or headache powder? This **excludes** acetaminophen (for example, Tylenol), ibuprofen (for example, Advil, Motrin or Nuprin), and naproxen (for example, Aleve).

Show participant List #1: Commonly Used Aspirin or Aspirin-Containing Products

No	0 ☐	→ **GO TO QUESTION 37**
Yes	1 ☐	
Unknown	9 ☐	→ **GO TO QUESTION 37**

35. How many days during the last four weeks did you take aspirin or aspirin-containing medication?

☐☐ Number of days

If number of days equals "00" → **GO TO QUESTION 37**

36. For what purpose are you taking aspirin? (*Interviewer: Do NOT read choices.)*

Participant mentioned avoiding heart attack or stroke	1 ☐
Participant did not mention avoiding heart attack or stroke	2 ☐

37. During the past four weeks, did you take any [other] medication for arthritis, fever, or muscle aches and pains, or cramps? *(Read bracketed "other" unless no medications were reported.)*

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

38. **Excluding** aspirin, acetaminophen (for example, Tylenol), and corticosteroids (for example prednisone), are you NOW taking other anti-inflammatory or arthritis medications on a regular basis? Common examples are shown on this list.

Show participant List #3: Commonly Used Non-Steroidal Anti-Inflammatory Drugs, NSAIDS

No 0 ☐ → **END QUESTIONNAIRE**
Yes 1 ☐
Unknown 9 ☐ → **END QUESTIONNAIRE**

39. Unless already recorded in Items B5-B29, record the following information for the medication identified by Item 38.

Already recorded 1 ☐

(a) Medication UPC		Medication name (b)
(c) Strength	(d) Units	

40. How many pills per week are you taking, on average?

☐☐ Number of pills per week