Interviewer_____ Study ID#_____
Date of Completion _____
Time of Completion_____

Blood Draw Information Form

1. List all medications, vitamins, and supplements, both prescription and over the counter, <you> have taken in the last month. Check box for MOST RECENT time frame when medication was last taken:

If no medications, vitamins, or supplements given in last month, check here: ___

Name of medication, vitamin or supplement	Last 4 hours	Last 24 hours	Last 3 days	Last 7 days	Last month
1) _____	☐	☐	☐	☐	☐
2) _____	☐	☐	☐	☐	☐
3) _____	☐	☐	☐	☐	☐
4) _____	☐	☐	☐	☐	☐
5) _____	☐	☐	☐	☐	☐
6) _____	☐	☐	☐	☐	☐
7) _____	☐	☐	☐	☐	☐
8) _____	☐	☐	☐	☐	☐
9) _____	☐	☐	☐	☐	☐
10) _____	☐	☐	☐	☐	☐

2. List any cold, flu or other illness you have had in the last 2 weeks. Check box for MOST RECENT time frame when illness occurred:

If no illness in last 2 weeks, check here: _____

Illness	Today	Last 2 days	Last 2 weeks
1) _____	☐	☐	☐
2) _____	☐	☐	☐

3) _____ ☐ ☐ ☐

4) _____ ☐ ☐ ☐

5) _____ ☐ ☐ ☐

3. Have <you> been exposed to tobacco smoke in the last 4 hours? __Yes __No

4a.What food or foods did <you> eat during their last meal or snack? List:

4b.What time was that food eaten? Time:

5. Has there been a significant event in <your> life during the past month? Examples of a significant event may include: illness or death in the family, divorce, moving or relocation, new school or day care, or other potentially stressful situation for <you>.
Describe: