Form 153 – Medication and Supplement Inventory
WHI Extension Study

Date Received: ☐☐-☐☐-☐☐ (MM/DD/YY) Reviewed By: ☐☐-☐☐☐		**- Affix label here-** Participant ID: __ __ __ __ - ___ ___ ___ - ___ First Name _____M.I._____ Last Name _____
Contact Type: ☐1 Phone ☐2 Mail ☐8 Other	Visit Type: ☐3 Annual ☐4 Non-Routine	☐FCA ☐OUI ☐OU2 Language: ☐1 English ☐2 Spanish
OFFICE USE ONLY		

Instructions:

To help us learn about the health of WHI participants, we would like to know about the medications and supplements you take.

This form asks about all of the prescription medications you are currently taking, and some of the over-the-counter medications and dietary supplements you may be taking.

If you would like to have a WHI staff member at the Clinical Coordinating Center complete this form with you over the phone, please feel free to call 1-800-218-8415.

Section A: Prescription Medications

This first section asks about **prescription medications** you are currently taking. This includes medications that you only take as needed, such as nitroglycerin. A prescription medication is one that is written (or phoned in) by your health care provider and must be filled at a pharmacy or drug store.

1. **Are you currently taking any medications that require a prescription from a doctor or health care provider**?

   ☐ 0 No → **Go to Section B on Page** 6

   ☐ 1 Yes → **Continue below**

For this section, you will need information from the labels on bottles or packaging that your prescription medications came in. To get started, please gather together all of your prescription medications so that this information is readily available as you complete the form. These medications may be in your medicine cabinet, refrigerator, or purse. It is important to include all of your prescriptions.

For each prescription medication, please answer the questions on the next page, including the medication's name and strength. You will find this information on the label of the pill bottle or container. An example of a prescription label and a completed medication question are shown below.

Example of a prescription label

Walgreens, Seattle, WA 98028
(DD/) Ph: 866-254-1669
RX#4599773 Sept. 6, 2005 Fill 1 of 1

DOE, JANE 206-566-0442
Take one capsule by mouth as directed in morning and at bedtime
Discard after Sept. 6, 2006 Mfr_____
Qty: 60 CAP Kroll, Phil MD
Phenytoin NA (Dilantin) 100 MG CAP

On the example prescription label, the medication name **Phenytoin NA (Dilantin)**, strength **100 MG**, and type **CAP** are all on one line.

Example of a completed question using the label example above

Prescription Medication	Write in Information Below:
Name of the medication (as written on label)	PHENYTOIN NA (DILANTIN)
Strength of the medication (as written on label)	100 MG
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	CAPSULE
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ■ 3 More than 1 year → **How many years?** 03

Please go to next page

2. For each of the prescription medications you are currently taking, please answer the questions below **using the label on the prescription bottle**. Please **print** clearly. You can use your best estimate about how long you have been taking the medication.

Complete all of the information in the table for *each* medication you take. There are enough boxes to write up to 10 different medications. When you have completed the information for all of your prescription medications, please go to **Section B** of the questionnaire on **page 6.**

Prescription Medication #1	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #2	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #3	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Continue on the next page, <u>or</u> go to Section B on page 6 if you have listed all your medications

Prescription Medication #4	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #5	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #6	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #7	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #8	**Write in Information Below**:
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #9	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #10	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → How many years? ☐☐

Continue on the next page, <u>or</u> go to Section B on page 6 if you have listed all your medications

3. In the previous question there was room to write up to 10 prescription medications. If you take more than 10, please list the names of those medications below. List only their names, and do not include any medications you already told us about in the prescription medications table. You may receive a call from the WHI Clinical Coordinating Center to gather more detailed information on these medications. If you do not take more then 10, skip to question 4.

a._____ f. _____

b._____ g. _____

c. _____ h. _____

d. _____ i. _____

e. _____ j. _____

Section B: Barriers to Prescription Medications

4. Have any of the following barriers prevented you from obtaining or taking any medications that have been prescribed for you? **(Please check all that apply.)**

- ☐ 1 My health insurance would not cover the medication.
- ☐ 2 The medication or copayment cost too much.
- ☐ 3 It is a problem for me to get to the medical facility/physician.
- ☐ 4 Taking the medication would be inconvenient.
- ☐ 5 I was concerned about possible side effects or complications from the medication.
- ☐ 6 I was concerned about missing work due to taking the medication.
- ☐ 7 My family discouraged me from taking the medication.
- ☐ 8 My friends discouraged me from taking the medication.
- ☐ 9 I am taking too many medications.
- ☐ 10 I don't like taking medications.
- ☐ 0 I have not experienced any barriers to taking prescription medications.

Please go to next page

Section C: Non-Prescription Medications

The next set of questions ask about certain **non-prescription medicines** you have taken **at least once a week in the past two weeks**. These are medicines that you can buy **over-the-counter without a prescription** from your health care provider.

5. **Please answer the following questions about the non-prescription medicines listed below.** For each type of medicine that you are taking, please write in the name and strength from the product label, how often you take it, and how long you have taken it. **For some types listed below, there is space to write in two products. If you are taking more than two, please write in just the two products that you take most often.** Note that the brand names provided below are just examples; write in the brand of the medicine you are taking.

5.1 Are you taking Aspirin, for example, Bayer, St. Josephs, Bufferin, Anacin, Excedrin, BC powder, baby aspirin, Doan's? (This does not include aspirin-free drugs such as Tylenol or Advil.)

☐ 1 Yes → / ☐ 0 No	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.2 Are you taking Anti-Inflammatory pain medicines, such as Advil, Aleve, Ibuprofen, Motrin, Naprosyn, Naproxen, Nuprin, Anaprox, or Orudis KT?

☐ 1 Yes → / ☐ 0 No	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

Please go to next page

5.3 Are you taking a second type of Anti-Inflammatory pain medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.4 Are you taking an Antacid or heartburn medicine, such as Axid, Pepcid AC, Prilosec, Tagamet, Zantac, Cimetidine, Famotidine, Omeprazole, or Ranitidine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.5 Are you taking a second type of Antacid or heartburn medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

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5.6 Are you taking natural female hormones, herbal estrogens, or phytoestrogens, such as Remifemin, DHEA pills, wild yam, soy or flax products, dong quai, or black cohosh?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.7 Are you taking a second type of natural female hormones, herbal estrogens, or phytoestrogens?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

6. In most states, some types of insulin can be purchased over-the-counter without a prescription. If you are currently taking insulin and you haven't included it on the list of your prescription medicines in Section A, please write it in question 6.1 below.

6.1 **Are you taking <u>over-the-counter insulin</u>**? If you listed insulin as a prescription medication in Section A, do not include it again here.

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 Less than once a day	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

Please go to next page

Section D: Dietary Supplements

In this final section, we ask about certain **vitamin or mineral supplements** you have taken **at least once a week in the past two weeks.**

7. Please answer the following questions about the **vitamin or mineral supplements** listed below. For each vitamin supplement that you are taking, please write in the name from the bottle/package, how often, and how long you have been taking it. Although you may be taking other supplements at this time, we are asking only for information on the supplements listed.

7.1 **Are you taking a Daily Multi-Vitamin Supplement that has 10 or more vitamins and/or minerals in one pill?** Examples are One-A-Day, Centrum, Theragran, Geritol.			
☐ 1 Yes → ☐ 0 No	**Product name and/or brand** (listed on the bottle) _____ _____ _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.2 **Are you taking Calcium/Vitamin D supplement mixture?** This is a pill that contains both Calcium and Vitamin D, but not in a multi-vitamin with several vitamins and minerals.			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Calcium Strength:** _____ **Vitamin D Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

Please go to next page

7.3 Are you taking Calcium as a single mineral supplement containing no other vitamins or minerals?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.4 **Are you** taking Vitamin D (Calciferol) as a single vitamin supplement containing no other vitamin or mineral?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

8. What is the date that you completed this form? ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋
Month Day Year

Thank you.
Please take a moment to review
any questions you may have missed.

S p a n i s h t r a n s l a t i o n u n d e r w a y

FORM: **153 – MEDICATION AND SUPPLEMENT INVENTORY**

Version: 1 – November, 2008

Description: Self-administered or interviewer-administered; 9-page booklet; key-entered at the Clinical Coordinating Center (CCC).

When used: Collected one time as part of the annual contacts for Clinical Trial (CT) and Observational Study (OS) participants enrolled in the WHI Extension Study. Completed at a non-routine contact when a participant death is reported.

Purpose: To collect updated information on the prescription and over-the-counter medications and nutritional supplements currently being used by participants.

GENERAL INSTRUCTIONS

1. The form is printed in both English (*Form 153*) and Spanish (*Form 153S*) versions.

2. The *Form 153* for WHI Extension Study participants will be labeled and mailed from the CCC directly to the participant.

    - The CCC mails the form to the participant and asks her to mail it back in a return envelope by a specified date. Following the CCC mailing, if the participant does not return the *Form 153* within 3 months of the first mailing, it will be sent again. If the form is not returned within 2 months of the second mailing, the form will be sent a third time. If the form is still not returned, CCC staff will contact the participants by telephone to collect the information from willing participants. The CCC will data enter the forms, and will use the Medispan database to code medications during the data entry process.

3. In the event that this form is collected by FC staff, the form should be sent to the CCC for data entry.

Item Instructions

Cover page

1.	Date Received	Fill in date received at the CCC.
2.	Reviewed By	Fill in standard 3-digit WHI employee ID of staff member reviewing the form for data entry.
3.	Contact Type	Mark appropriate box (phone, mail, other).

Prescription Medications

1.	Currently Taking Prescription Medications	No/Yes. Participants indicating "No" skip to Q 4 in Section B.
2a.	Prescription Medication Name	For each prescription medication listed, participant records the name of the medication.
2b.	Prescription Medication Strength	For each prescription medication listed, participant records the strength of the medication.
2c.	Prescription Medication Type	For each prescription medication listed, participant records the medication type, e.g., capsule, tablet, cream, liquid, suppository, inhaler, injection.
2d.	Prescription Medication Duration	For each prescription listed, participant indicates length of time taking medication. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 provide the actual number of years.

Repeat 2a-d for each prescription medication, up to 10 medications.

3.	Other Prescription Medications	Participant records name of any other prescription medications they are taking, if there was not enough room to list them in item 2 above.
4.	Barriers to Prescription Medications	Participant checks all barriers that apply.

Non-Prescription Medications

Participant indicates the following information for each of these non-prescription medications: aspirin, anti-inflammatories, antacid or heartburn medicines, and natural female hormones. Participants can list up to 2 types of anti-flammatories, antacids, and natural hormones.

5.	Taken the Non-Prescription Medication in Past Two Weeks	Yes/No. Participants indicating "No" skip to the next non-prescription medication.
5.	Name of the Non-Prescription Medication	For each medication they are taking, participant provides the name of the product.
5.	Strength of the Non-Prescription Medication	For each medication they are taking, participant provides the strength of the product.
5.	Non-Prescription Medication – Frequency	For each medication they are taking, participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week; 5. 1-3 days a month.
5.	Prescription Medication Duration	For each medication they are taking, participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.

6.	Over-the-Counter Insulin	Participants are asked if they are taking over-the-counter insulin Yes/No. Those who indicate yes, are asked to provide the name of the product, the strength, how often it is taken (1. Once a day or more; 2. Less than once a day) and how long it has been taken (1. Less than a month; 2. 1-12 months; 3. More than 1 year. How many years?)

Dietary Supplements

7 M/V.	Daily Multi-Vitamin Supplement – Taken in Past 2 Weeks	Yes/No. Participants indicating "No" skip to the next supplement.
	Daily Multi-Vitamin Supplement – Product Name	Participant provides the name of the product.
	Daily Multi-Vitamin Supplement – Frequency	Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
	Daily Multi-Vitamin Supplement – Duration	Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.
7 Cal/ VitD.	Calcium/Vitamin D Supplementation Mixture – Taken in Past 2 Weeks	Yes/No. Participants indicating "No" skip to the next supplement.
	Calcium/Vitamin D Supplementation Mixture – Product Name	Participant provides the name of the product.
	Calcium/Vitamin D Supplementation Mixture – Strength	Participant provides strength of calcium and strength of vitamin D.
	Calcium/Vitamin D Supplementation Mixture – Frequency	Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
	Calcium/Vitamin D Supplementation Mixture – Duration	Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.
7 Cal.	Calcium Single Supplement – Taken in Past 2 Weeks	Yes/No. Participants indicating "No" skip to the next supplement.
	Calcium Single Supplement – Product Name	Participant provides the name of the product.
	Calcium Single Supplment - Strength	Participant provides strength of calcium.
	Calcium Single Supplement – Frequency	Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
	Calcium Single Supplement – Duration	Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.

7 VitD.	Vitamin D Single Supplement – Taken in Past 2 Weeks	Yes/No. Participants indicating "No" skip to the next supplement.
	Vitamin D Single Supplement – Product Name	Participant provides the name of the product.
	Vitamin D Single Supplment - Strength	Participant indicates strength of the vitamin D.
	Vitamin D Single Supplement – Frequency	Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
	Vitamin D Single Supplement – Duration	Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.
8.	Date	Month/Day/Year the form was completed.