



(affix label here)

Patient ID Number	<input type="text"/>	Site	<input type="text"/>	Sub-site	<input type="text"/>	Sequential ID	<input type="text"/>	<input type="text"/>	<input type="text"/>
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SEARCH Medication Inventory *(Interviewer Administered)*

1. Now I would like to know all of your currently prescribed medication(s), including your insulin and any other diabetes medication. Are you taking prescribed medication(s)?

Yes **If Yes, what prescribed medication(s) are you currently taking?** *(Interviewer: check all insulins and other diabetes medications and write the name of any other medication).*

No

2. Thank you. Now, for each medication(s) that you just told me about, please let me know if you have taken it in the past two days. *(Interviewer: review the medication(s) reported and check yes or no).*

Insulin Medications	Have you taken in last 2 days? <i>(Check yes or no)</i>
<input type="checkbox"/> Aspart (Novolog)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lispro (Humalog, Humulin H)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Regular (Novolin R, Humulin R)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> NPH (Novolin N, Humulin N)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Glargine (Lantus)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Premixed Insulins (70/30, 75/25, 50/50)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other insulin <i>(please write in medication name below)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other injectable medications <i>(please write in medication name below)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx)

Oral Medications for diabetes

Have you taken in last 2 days?
(Check yes or no)

Metformin (Glucophage) Yes No

Acarbose (Precose, Prandase) Yes No

Glimepiride (Amaryl) Yes No

Glipizide (Glucotrol) Yes No

Glyburide (Micronase, Diabeta,
Glynase) Yes No

Pioglitazone (Actos)..... Yes No

Repaglinide (Prandin) Yes No

Rosiglitazone (Avandia) Yes No

Rosglitazone/Metformin (Avandamet) Yes No

Nateglinide (Starlix) Yes No

Other Medications (including diabetes medications not listed above)

Have you taken in last 2 days? *(Check yes or no)*

1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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