OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Medication Use Questionnaire

ID NUMBER:									FORM CODE: MUE VERSION: 1, 6/3/2016	Contact Occasion	0	2	SEQ #		1

ADMINISTRATIVE INFORMATION

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

0b. Staff ID: ☐☐☐

Instructions: *This form should be completed during the participant's visit. Enter information provided by the participant for each question. Record medication information in the "Medication record" section as it applies. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. Reception

As you know, the SOL records all prescription and over-the-counter medications used in the past four weeks, including cold, allergy, vitamins, minerals and dietary supplements. These medications include solid and non-solid medications that you may swallow, inhale, apply to the skin, inject, implant, or place in the ears, eyes, nose, mouth, or any other part of the body. The materials mailed for your appointment included a 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 ☐ → **STOP; Thank ppt. and close form**

   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 ☐ **GO TO SECTION C, QUESTION 26**

   Yes 1 ☐

4. Describe method of follow-up to be used: _____

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B. Medication Record

Confirm, or carefully copy the MEDICATION NAME into "a" using upper case letters. Confirm, or copy the formulation STRENGTH (weight for solids and concentration for non-solids), using periods to indicate decimal points. Confirm, or copy the UNITS used to measure strength, using upper case letters and standard abbreviations. For combination medications, use a forward slash (/) to separate active ingredients, corresponding strengths, and units.

#			Medication name (a)
5.	(b) Strength	(c) Units	
6.	(b) Strength	(c) Units	
7.	(b) Strength	(c) Units	
8.	(b) Strength	(c) Units	
9.	(b) Strength	(c) Units	
10.	(b) Strength	(c) Units	
11.	(b) Strength	(c) Units	
12.	(b) Strength	(c) Units	
13.	(b) Strength	(c) Units	
14.	(b) Strength	(c) Units	
15.	(b) Strength	(c) Units	
16.	(b) Strength	(c) Units	
17.	(b) Strength	(c) Units	
18.	(b) Strength	(c) Units	
19.	(b) Strength	(c) Units	
20.	(b) Strength	(c) Units	

21.	(b) Strength	(c) Units	
22.	(b) Strength	(c) Units	
23.	(b) Strength	(c) Units	
24.	(b) Strength	(c) Units	

25. Total number of medications in bag ☐☐

C. Medication Use Interview

Now I would like to ask about a few specific medications.

26. Were any of the medications you took during the last four weeks for:	**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 ☐
m. Depression	0 ☐	1 ☐	9 ☐
n. Anxiety	0 ☐	1 ☐	9 ☐
o. Glaucoma	0 ☐	1 ☐	9 ☐
p. A disease of the thyroid	0 ☐	1 ☐	9 ☐