Multi-Ethnic Study of Atherosclerosis

Exam 4

Medications

Interviewer Administered

Participant Id#:

Acrostic:

Date: ☐☐ / ☐☐ / ☐☐☐☐

Section A Medication Reception

As you know, the Multi-Ethnic Study of Atherosclerosis will be describing all medications its participants are using, both prescription and over-the-counter. These include pills, liquid medications, skin patches, eye drops, creams, salves, inhalers and injections, as well as cold or allergy medications, vitamins, herbal remedies and other supplements. The letter you received about this appointment included a plastic medications bag for all your current medications and asked you to bring them to the clinic. Have you brought this bag with you? Are these all the medications that you have taken in the past two weeks?

- ○ **YES** → May I see them? *Continue with Section B*
- ○ **REFUSED** → *Record reason for refusal in Comments Section*
- ○ **NO** → *Make arrangements to obtain*
- ○ **TOOK NO MEDICINES** → *Go to end of form*

Section B Prescription Medications

1 *Copy the name of the medicine, the strength **(include units)**, and the total number of doses prescribed per day/week/month. Include all pills, skin patches, eye drops, creams, salves, injections, and inhalers (puffers).*

2 On the average during the last two weeks, how many of these pills did you take a day/week/month?

Medication Name *Print the first 20 letters only - Please print clearly*	**Strength(mg, IU, etc.)** *Write the decimal as one of the digits*	**Number Prescribed** *Circle: Day, Week, Month*	**PRN Medicine?**	
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M
		___ D W M	___ Y N	___ D W M

Number unable to transcribe: ☐☐

DO NOT SCAN

0051523679

Section C Over-the-Counter Medications

3 *Copy the name of the medicine, the strength **(include units)**, and the total number of doses per day/week/ month. Include all pills, liquid medications, eye drops, creams, salves, inhalers (puffers), and supplements.*

2 On the average during the last two weeks, how many of these did you take a day/week/month?

Medication Name *Print the first 20 letters only - Please print clearly*	**Strength(mg, IU, etc.)** *Write the decimal as one of the digits*	
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M

Number unable to transcribe: ☐☐

Comments:

For MESA Field Center Use Only:

Interviewer ID: ☐☐☐ Reviewer ID: ☐☐☐ Data Entry ID: ☐☐☐

DO NOT SCAN

6195523674