



Visit: SV2  
ID: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

### Baseline Medication Use Questionnaire

1. Do you regularly (at least 5 days per month) take any prescription medicines, over the counter medications, or nutritional supplements? ..... **Yes**  **No**

2. **If yes** to question 1, please list the medications: (Use the back of the page if you need more space)

Name of Medication	Date you last took a dose of the medication.	Reason for use:
1. _____	___/___/___	_____
2. _____	___/___/___	_____
3. _____	___/___/___	_____
4. _____	___/___/___	_____
5. _____	___/___/___	_____
6. _____	___/___/___	_____
7. _____	___/___/___	_____
8. _____	___/___/___	_____
9. _____	___/___/___	_____
10. _____	___/___/___	_____
11. _____	___/___/___	_____
12. _____	___/___/___	_____
13. _____	___/___/___	_____

ID: \_\_\_\_\_

**Yes**   **No**

3. Have you taken any medications for pain in the last month?.....  1    2

*(see attached list of pain medications)*

4. <b>If yes</b> , how many times did you take it?.....rarely <input type="checkbox"/> 2
most days <input type="checkbox"/> 3
every day <input type="checkbox"/> 4

ID: \_\_\_\_\_

**Medication Use Review: (to be completed by clinic staff after reviewing page 1 and the medications brought in by the participant)**

5. List all medications and/or supplements used regularly (at least 5 days per month) by the participant:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_
- f. \_\_\_\_\_
- g. \_\_\_\_\_
- h. \_\_\_\_\_

6. Is the participant taking any of the following exclusionary medications?

	<b>Yes</b>	<b>No</b>
a. blood pressure medications (see list) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. weight loss medications (see list).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. anti-psychotic medications (see list) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. mood stabilizers (see list).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. oral steroids, oral breathing medications other than inhalers (see list) ....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. insulin or oral hypoglycemics (see list) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2

7. Is the participant taking any of the following non-exclusionary medications?

	<b>Yes</b>	<b>No</b>
a. lipid lowering medications (see list) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. oral contraceptive pills (see list) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. hormone replacement therapy (see list).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. calcium supplements .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. vitamins .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. minerals .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2

\_\_\_\_\_  
Clinician signature

\_\_\_\_\_  
Date

Reviewed by (staff ID): _____
Entered by (staff ID): _____

## Overview

The purpose of this self/interviewer-administered questionnaire is to identify individuals who are taking medications that would exclude them from further participation in the study. This form is administered during the SV2 Visit. Similar follow-up medication forms are administered before all follow-up blood pressure assessments.

If the participant is eligible to continue and reports taking *any* medications, a PREMIER clinician must review and sign the form assuring that the participant is not using any exclusionary products. If the participant is taking a medication that is clearly exclusionary, the form does not need to be reviewed by a clinician.

## Administration Instructions

Place ID label on pages 1 – 3.

Fill out the visit date on page 1. Be sure to use a four digit year.

The first two pages of this form should be completed by the participant and the third page should be completed by the interviewer.

<u>Page</u>	<u>Question</u>	<u>Special Administration Instructions (if any)</u>
1	1	If Yes, fill out Q2. If No, skip to Q3.
	2	If Q1 = Yes, this question may not be left blank. Record any medications or nutritional supplements regularly taken by the participant in the space provided.
2	3	If Yes to Q3, fill out Q4.
	4	If Q3 = Yes, this question may not be left blank. Mark only one response with an "X". This question is not exclusionary.
3	<b>Page 3 to be completed by clinic staff only.</b>	
	5	Record all medications and/or supplements used by the participant. Refer to page 1 and the medications brought in by the participant. Only list medications that are taken at least 5 times per month.
	6	See Coding Instructions
	7	See Coding Instructions

## Coding Instructions

Using the list of medications in Q5, code each item under Q6 as Yes or No. Use the attached lists of medications to identify medications in each category. These lists are extensive, but not exhaustive, so consult a clinician if in doubt about any medication.

Items under Q6 are exclusionary if the answer is Yes. Note that Q6e includes oral steroids taken for any reason, not just as an asthma medication, but does not include topical steroids.

Next, use the list of medications in Q5 to code each item under Q7 as Yes or No. These items are not exclusionary.

If the participant is eligible to continue and reports taking *any* medications, a PREMIER clinician (MD, physician assistant, nurse practitioner) must review and sign the form assuring that the participant is not using any exclusionary products. If the participant is taking a medication that is clearly exclusionary, the form does not need to be reviewed by a physician.

## Review Instructions

- ? Page 1 should be dated
- ? Pages 1 – 3 should have correct ID# labels.
- ? For all eligible participants with any medications listed under Q5, and no exclusionary medications checked under Q6, the clinician's signature and date should be filled in (at the bottom).
- ? If the participant is INELIGIBLE (at least one "Yes" response to items 6 a-f), enter "ineligible" on the SV2 Visit Form (#10) for the Baseline Medication Use Questionnaire outcome.
- ? If the participant is ELIGIBLE (all items 6a-f should be coded NO), enter "ELIGIBLE" on the SV2 Visit Form (#10) for the Medication Use Questionnaire outcome.

## Additional Instructions

Only questions 3, 4, 6, and 7 are entered.

## **Pain Medications List (Question 5)**

<b><u>Generic name</u></b>	<b><u>Brand name</u></b>
Acetaminophen	Tylenol
Aspirin	Bayer, Bufferin, Ecotrin
Aspirin & Bicarbonate	Alka-Seltzer
Aspirin & Caffeine	Anacin
Diclofenac	Cataflam, Voltaren
Diflunisal	Dolobid
Etodolac	Lodine
Fenoprofen	Nalfon
Flurbiprofen	Ansaid
Ibuprofen	Advil, Motrin, Nuprin
Indomethacin	Indocin
Ketoprofen	Actron, Orudis, Oruvail
Ketorolac	Toradol
Mefenamic Acid	Ponstel
Nabumetone	Relafen
Naproxen	Aleve, Anaprox, Naprelan, Naprosyn
Oxaprazosin	Daypro
Piroxicam	Feldene
Salicylate	Trilisate
Salsalate	Disalcid, Salflex
Sulindac	Clinoril
Tolmetin	Tolectin
Tramadol	Ultram

## Blood pressure medications (question 8, part a)

<u>Generic name</u>	<u>Brand name</u>
Acebutolol	Sectral
Amiloride	Midamor, Moduretic
Amlodipine	Norvasc
Atenolol	Tenormin
Benazepril	Lotensin, Lotrel
Bepridil	Vascor
Betaxolol	Kerlone
Bisoprolol	Zebeta, Ziac
Bumetanide	Bumex
Candesartan	Atacand
Captopril	Capoten, Capozide
Carteolol	Cartrol
Carvedilol	Coreg
Chlorthalidone	Hygroton
Clonidine	Catapres, Clonidine, Combipres
Diltiazem	Cardizem, Dilacor, Tiazac
Doxazosin mesylate	Cardura
Enalapril maleate	Vasoretic, Vasotec
Ethacrynic Acid	Edecrin
Filodipine	Plendil
Fosinopril sodium	Monopril
Furosemide	Lasix
Hydralazine	Apresoline, Apresazide
Hydrochlorothiazide	Esidrix, Hydrodiuril, Microzide
Indapamide	Lozol
Irbesartan	Avapro
Isradipine	Dynacirc
Labetolol	Normodyne, Trandate
Lisinopril	Prinivil, Prinzide, Zestoretic, Zestril
Losartan potassium	Cozaar, Hyzaar
Methyldopa	Aldoclor, Aldomet, Aldoril
Metoprolol	Lopressor, Toprol

(continued on next page)

**Blood pressure medications (question 8, part a, continued)**

<b><u>Generic name</u></b>	<b><u>Brand name</u></b>
Minoxidil	Loniten
Moexipril	Univasc
Nadolol	Corgard, Coroxide
Nicardipine	Cardene
Nifedipine	Adalat, Procardia
Nimodipine	Nimotop
Nisoldipine	Sular
Penbutolol	Levitol
Pindolol	Visken
Prazosin	Minipress, Minizide
Propranolol	Inderide, Inderol
Quinapril	Accupril
Ramipril	Altace
Sotalol	Betapace
Spironolactone	Aldactizide, Aldactone
Telmisartan	Micardis
Terazosin	Hytrin
Timolol	Timolide
Trandolapril	Mavik
Triamterene	Maxzide, Dyazide, Dyrenium
Valsartan	Diovan
Verapamil	Calan, Covera, Isoptin, Verelan

## Weight-loss Drugs (Question 8, part b)

<u>Generic name</u>	<u>Brand name</u>
Benzphetamine	Didrex
D-Amphetamine	Dexadrine, Dextrostat
Dexfenfluramine	Redux
Diethylpropion	Tenuate, Tenuate Dospan, Tepanil
Fenfluramine	Pondimin
Mazindol	Mazanor, Sanorex
Methamphetamine	Desoxyn
Orlistat	Xenical
Phendimetrazine	Bontril, Prelu-2, Plegine, X-trozone
Phenmetrazine	Preludin
Phenylpropanolamine	Accutrim, Dexatrim
Phentermine	Adipex, Fastin, Ionamin, Obenix, Oby-Cap, Oby-Trim, Pro-Fast, Zantrol
Sibutramine	Meridia

\* All weight-loss medications affect blood pressure except for Xenical (Orlistat)

### Anti-psychotics (Question 8, part c)

<u>Generic name</u>	<u>Brand name</u>
Chlorpromazine	Thorazine
Chlorprothixene	Taractan
Clozapine	Clozaril
Flupenthioxol	Fluanxol
Fluphenazine	Permitil, Prolixin
Haloperidol	Haldo*
Hydroxyzine	Vistaril*
Loxapine	Loxitane
Mesoridazine	Serentil
Methotrimeprazine	Nozinan
Molindone	Moban
Olanzapine	Zyprexa
Perphenazine	Trilafon
Pimozide	Orap
Pipotiazine	Piportil
Prochlorperazine	Compazine*
Promazine	Sparine
Quetiapine	Seroquel
Risperidone	Risperdal
Sulpiride	
Thioridazine	Mellaril
Thiothixene	Navane
Trifluoperazine	Stelazine

### Mood stabilizers (Question 8, part d)

<u>Generic name</u>	<u>Brand name</u>
Carbamazepine	Depakote
Divalproex	Tegretol*
Lithium	Cibalith, Eskalith, Lithobid, Lithonate, Lithotabs

\* These drugs may be taken for other purposes besides psychosis or bipolar disorder. Participant should be questioned about the reason these were prescribed before being excluded. If the drug was taken for some other reason, recode 8c or 8d to "No".

### Oral steroids (Question 8, part e)

<u>Generic name</u>	<u>Brand name</u>
Betamethasone*	Celestone*
Dexamethasone	Decadron, Dexone, Hexadrol
Fludrocortisone	Florinef
Hydrocortisone	Cortef, Hydrocortone
Methylprednisolone*	Medrol*
Prednisolone	Delta-Cortef, Prelone
Prednisone	Deltasone, Orasone

### Oral breathing medications other than inhalers (Question 8, part e)

<u>Generic name</u>	<u>Brand name</u>
Albuterol sulfate*	Proventil*, Ventolin*, Volmax*
Aminophylline	Amesec, Phyllocontin, Somophyllin
Dyphylline	Dilor, Lufyllin, Neothylline
Guaifenesin/theophylline	Elixophylline
Metaproterenol sulfate*	Alupent*, Metaprel*
Oxtriphylline	Choledyl
Terbutaline sulfate	Brethine
Theophyllin	Ami-Rax, Asbron, Azpan, Bronkolixir, Bronkotabs, Constant-T, Elixophyllin, Hydrophed, Labid, Marax, Quadrinal, Quibron, Respbid, Slo-Bid, Slo-Phyllin, Somophyllin, Tedral, T.E.P., Theo-24, Theochron, Theodrine, Theo-Dur, Theolair, Theophyl, T-Phyl, Uni-Dur, Uniphyl

\*Exclusionary only if in oral form (tablet or syrup).

### Insulin/oral hypoglycemics (Question 8, part f)

<u>Generic name</u>	<u>Brand name</u>
Acetohexamide	Dymelor
Chlorpropamide	Diabinese
Glemipiride	Amaryl
Glipizide	Glucotrol
Glyburide	Diabeta, Glynase, Micronase
Insulin	Actrapid, Humalog, Humulin, Iletin, Iletin, Insulatard, Isophane, Lentard, Lente, Mixtard, Monotard, Novolin, Protaphane, Semilente, Semitard, Ultratard, Velosulin
Metformin	
Tolazamide	Tolinase
Tolbutamide	Orinase

### Lipid-lowering drugs (Question 9, item a)

<u>Generic name</u>	<u>Brand name</u>
Atorvastatin	Lipitor
Bizafibrate	Bezalip
Cholestyramine	Cholybar, Locholest, Prevalite, Questran
Clofibrate	Atromid-S
Colestipol	Colestid
Dextrothyroxine sodium	Choloxin
Fluvastatin	Lescol
Gemfibrozil	Lopid
Lovostatin	Mevacor
Nicotinic acid	Niacin, Niacinamide, Niacor, Nicobid, Nicotinamide, Slo-Niacin
Pravastatin	Pravachol
Probucol	Lorelco
Simvastatin	Zocor

### Oral contraceptives (Question 9, item b)

<u>Generic name</u>	<u>Brand name</u>
Desogestrel	Desogen, Mircette, Ortho-Cept
Ethinodiol	Demulen, Ovulen, Zovia
Levonorgestrel	Alesse, Leveln, Levora, Nordette, Tri-Levlen, Tri-Phasil
Medroxyprogesterone	Depo-Provera
Mestranol/norethynodrel	Enovid
Norethin A-ET	Loestrin, Norlestrin
Norethindrone	Brevicon, Enovid, Estrastep, Genora, Jenest, Micronor, Modicon, Necon, Nelova, Norinyl, Nor-Q-D, Ortho-Novum, Ovcon, Tri-Norinyl
Norgestimate	Ortho-Cyclen, Ortho Tri-Cyclen
Norgestrel	Lo/Ovral, Ovral, Ovrette
Progesterone	Progestacert

### Hormone replacement therapy (Question 9, part c)

<u>Generic name</u>	<u>Brand name</u>
Chlorotrianesine	Tace
Conjugated estrogens	Premarin, Premphase, Prempro
Diethylstilbestrol	
Esterified estrogens	Estratab, Estratest, Menest, Milprem, PMB
Estradiol	Alora, Climara, Deladumone, Delestrogen, Depo, Estrace, Estraderm, Fempatch, Vivelle
Estrone	Theelin
Estropipate	Ogen, Ortho
Ethinyl estradiol	Estinyl, Feminone
Quinestrol	Estrovis