Multi-Ethnic Study of Atherosclerosis

Exam 3

MeSA

Medications

Interviewer Administered

Participant Id#:

Acrostic:

enterDt

Date: ☐☐ / ☐☐ / ☐☐☐☐

Section A   Medication Reception   otc = 0 for all meds on this page

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*   **allmed**   ○ **NO** ➜ *Make arrangements to obtain*

○ **REFUSED** ➜ *Record reason for refusal in Comments Section*   ○ **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

mname

Strength(mg, IU, etc.) *Write the decimal as one of the digits* **mdose**

Number Prescribed *Circle: Day, Week, Month* **rxday**

PRN Medicine? **otc**

tknday

Medication Name	Strength	Number Prescribed	PRN Medicine?	tknday
		___ 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

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DO NOT SCAN

03/06/2004

6052427376

otc = 1 for all meds on this page

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

mname	mdose	tknday
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
		___ D W M
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Comments:

cmmnt1

cmmnt2

For MESA Field Center Use Only:

Interviewer ID: [recid]   Reviewer ID: [ ]   Data Entry ID: [deid]

DO NOT SCAN