# Concomitant Medication

## Concomitant Medications

[Revision: Initial revision of study]

(Visit ID = 90 / Visit Display Name = Concomitant Medication / Visit Abbrev = CM / PageID = 10 / Page Display Name = Concomitant Medications / Description = Concomitant Medications)

* Any concomitant medications?
- ○ No
- ○ Yes

If yes, please record on the Concomitant Medications Details form.

# Concomitant Medications Details

[Revision: Initial revision of study]

(Visit ID = 90 / Visit Display Name = Concomitant Medication / Visit Abbrev = CM / PageID = 20 (*) / Page Display Name = Concomitant Medications Details / Description = Concomitant Medications Details)

| | | |
|---|---|---|
| Sequence Number | | |
| * Date of Contact | | (DD-MMM-YYYY) |
| * Reporter of Information | ○ Patient<br>○ Obstetrician<br>○ Gynecologist<br>○ Infant healthcare provider<br>○ Other | |
| * Other, Specify | | |
| | | |
| * Medication name | | |
| * Indication | | |
| * Dose | | (format xxxxxx.xx) |

| | |
|---|---|
| * Unit | ○ Capsule<br>○ mL<br>○ g<br>○ Grain<br>○ gtt<br>○ IU<br>○ U<br>○ Application<br>○ ug<br>○ Tablet<br>○ 10^6 IU<br>○ Tbsp<br>○ tsp<br>○ mg<br>○ Puff<br>○ Implant<br>○ Spray<br>○ Other |
| * Unit, Other specify | |

| | | |
|---|---|---|
| * Frequency | ○ Once<br>○ One a day (QD)<br>○ Twice a day (BID)<br>○ Three times a day (TID)<br>○ Four times a day (QID)<br>○ Every other day (QOD)<br>○ Every morning (QM)<br>○ Every Week<br>○ As needed (PRN)<br>○ Continuous<br>○ Other | |
| * Frequency, Other specify | | |
| * Route | ○ Intramuscular<br>○ Intravenous<br>○ Ophthalmic<br>○ Oral<br>○ Nasal<br>○ Rectal<br>○ Respiratory (Inhalation)<br>○ Subcutaneous<br>○ Sublingual<br>○ Topical<br>○ Transdermal<br>○ Vaginal<br>○ Other | |
| * Route, Other specify | | |
| * Start Date | | (UNK-UNK-UNK) |

| | | |
|---|---|---|
| * Ongoing? | ○ No<br>○ Yes | |
| * Stop Date | | (UNK-UNK-UNK) |