Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ /20 _ _ Initials: _____
mm dd yy mm dd yy

Patient ID __ __ __ - __ __ __ __ - __ __ **Visit:____**

For office use only.

Medications (MED) –Version 08/28/2006

Form Completion Date __ __ / __ __ / 20 __ __
mm dd yy

1. Have you taken a multi-vitamin in the **past 90 days?**

For Office Use only
Verified by Container?
☐ No ☐ Yes

☐ 0. No ☐ 1. Yes (please bring your multi-vitamins to your next LABS visit.)

Skip to Question 2

1.1 What kind of multi-vitamin do you take *(check only one)*?

☐ Adult ☐ Child
☐ Geriatric ☐ Prenatal
☐ Bariatric Specialty Blend ☐ None of the above

1.2 Does your multi-vitamin contain minerals?

☐ No ☐ Yes

1.3 How often do you take a multi-vitamin *(check only one)?*

☐ No longer taking a multivitamin ☐ Weekly (1-6 times per week)
☐ Daily (1 or more times a day) ☐ Monthly/Rarely (0-3 times per month)

2 Have you taken any other vitamins or minerals in the **past 90 days** (vitamins other than the multi-vitamins included in question 1)?

☐ 0. No ☐ 1. Yes (please bring vitamins/minerals to your next LABS visit.)

Skip to Question 3

2.1 What kind of kind of vitamins/minerals do you take? (*check yes/no for each)*

No	**Yes**	**Medication (taken by mouth)**	**If yes, how often do you take it?**				***For Office Use Only*** Verified by Container?
			No longer taking	**Daily (1 or more times/day)**	**Weekly (1-6 times/week)**	**Monthly /Rarely (0-3 times/mo)**	
☐	☐	Iron	☐	☐	☐	☐	☐ No ☐ Yes
☐	☐	Folate	☐	☐	☐	☐	☐ No ☐ Yes
☐	☐	Calcium	☐	☐	☐	☐	☐ No ☐ Yes
☐	☐	Vitamin D	☐	☐	☐	☐	☐ No ☐ Yes
☐	☐	Vitamin B12	☐	☐	☐	☐	☐ No ☐ Yes

No	**Yes**	**Medication (injection)**	**If yes, how often do you take it?**				
			Daily	Weekly	Monthly	Every other month	Every 3 months
☐	☐	Vitamin B12	☐	☐	☐	☐	☐

3. In the **past week**, have you taken any pain medication, prescription or over-the-counter, for your back, hip(s), knee(s) or ankle(s)? *(check "no" or "yes" to each)*:

Specify for which:

	No	Yes	*If yes*	Specify the number of **days** taken in the past week:
3.1 Your back	☐	☐	→	_____
3.2 Your hip(s)	☐	☐	→	_____
3.3 Your knee(s)	☐	☐	→	_____
3.4 Your ankles(s)	☐	☐	→	_____

4. In the **past week**, have you taken prescription or over-the-counter medication for acid reflux, heartburn or a hiatal hernia? ☐ 0. No ☐ 1. Yes

If yes,

4.1 Specify the number of **days** you have taken medication in the last week for this: _____

5. In the **past week**, have you taken any low-dose aspirin (such as baby aspirin or one regular strength aspirin tablet) for reasons **other than for pain, such as to prevent heart attack or stroke**? ☐ 0. No ☐ 1. Yes

If yes,

5.1 Specify the number of **days** taken in the past week: _____

6. Have you taken any medications in the **past 90 days** that can only be purchased with a prescription from your doctor?

☐ 0. No ☐ 1. Yes (please bring your prescription medications to your next LABS visit.)

↓

Please print the name (as listed on your medication bottle/container) of each prescription medication that you have taken in the **past 90 days**.

Medication Name	**How often do you take it?**					***For Office Use Only*** Verified by Container?
	No longer taking	**Daily** (1 or more times/day)	**Weekly** (1-6 times/week)	**Monthly /Rarely** (0-3 times/mo)	**As Needed**	
1.	☐	☐	☐	☐	☐	☐ No ☐ Yes
2.	☐	☐	☐	☐	☐	☐ No ☐ Yes
3.	☐	☐	☐	☐	☐	☐ No ☐ Yes
4.	☐	☐	☐	☐	☐	☐ No ☐ Yes
5.	☐	☐	☐	☐	☐	☐ No ☐ Yes
6.	☐	☐	☐	☐	☐	☐ No ☐ Yes
7.	☐	☐	☐	☐	☐	☐ No ☐ Yes
8.	☐	☐	☐	☐	☐	☐ No ☐ Yes
9.	☐	☐	☐	☐	☐	☐ No ☐ Yes
10.	☐	☐	☐	☐	☐	☐ No ☐ Yes
11.	☐	☐	☐	☐	☐	☐ No ☐ Yes
12.	☐	☐	☐	☐	☐	☐ No ☐ Yes
13.	☐	☐	☐	☐	☐	☐ No ☐ Yes
14.	☐	☐	☐	☐	☐	☐ No ☐ Yes
15.	☐	☐	☐	☐	☐	☐ No ☐ Yes
16.	☐	☐	☐	☐	☐	☐ No ☐ Yes
17.	☐	☐	☐	☐	☐	☐ No ☐ Yes
18.	☐	☐	☐	☐	☐	☐ No ☐ Yes
19.	☐	☐	☐	☐	☐	☐ No ☐ Yes
20.	☐	☐	☐	☐	☐	☐ No ☐ Yes
21.	☐	☐	☐	☐	☐	☐ No ☐ Yes
22.	☐	☐	☐	☐	☐	☐ No ☐ Yes
23.	☐	☐	☐	☐	☐	☐ No ☐ Yes
24.	☐	☐	☐	☐	☐	☐ No ☐ Yes
25.	☐	☐	☐	☐	☐	☐ No ☐ Yes
26.	☐	☐	☐	☐	☐	☐ No ☐ Yes
27.	☐	☐	☐	☐	☐	☐ No ☐ Yes
28.	☐	☐	☐	☐	☐	☐ No ☐ Yes

MEDICATIONS (MED)

PURPOSE:	To collect information regarding medications taken by patients aged 18 years or older enrolled in LABS-1, who have provided informed consent for LABS-2, prior to bariatric surgery.
PERSON(S) RESPONSIBLE: **SOURCES OF INFORMATION:**	Clinician/Coordinator Patient
WHEN TO ADMINISTER FORM:	Once patient provides informed consent for LABS-2, prior to surgery. This questionnaire should be completed at the clinical visit or sent to patient by mail for patient to complete at home and return to coordinator prior to bariatric surgery. If the patient completes the MED at home, the coordinator or other study staff must review the document at patient's clinic visit to ensure that all fields have been completed appropriately. Prior to the clinical visit, patients should be instructed to bring in all of their current medication.
GENERAL INSTRUCTIONS (Patient)	This questionnaire is to be completed by the patient. If the patient is not able to complete the form without help, the coordinator or patient designee may read the questions and answers to the patient. If the patient intends to complete the questionnaire at the clinical visit, prior to the clinical visit, patients should be instructed to bring in all of their current medication.
GENERAL INSTRUTIONS: (Clinician)	After patient completes survey: (1) Review the form for any missing items. Follow-up with patient if necessary to record missing items, or to clarify responses. (2) Make sure that each item has a single response marked, unless directions state otherwise. (3) If the patient does not understand the question, a coordinator or patient designee may read the question to them. Do not answer the question. Indicate whether the response is unknown or if the patient refused to provide an answer.
SCORING ALGORITHM:	**N/A**

DATA SECTION	COMPLETION INSTRUCTIONS
PATIENT ID:	Record the patient's ID number. The ID number is assigned via the ID registration application of the MATRIX Web Data Management System (MATRIX). Instructions on using this application are included in the MATRIX Manual. *NOTE: The patient ID number is the same as that assigned to the patient as part of the LABS-1 study.*
VISIT:	Record the visit number that the MED corresponds to on the right hand corner of the cover page
FORM COMPLETION DATE:	Patient records date of form completion (mm/dd/20yy)
	1. If the patient has taken multi-vitamins in the past 90 days, this item should be checked yes. If not, then the patient should skip to the next question. If yes, 1.1 Check what kind of multi-vitamin that is being taken. 1.2 Check whether or not the vitamin contains minerals. 1.3 Check how often the multi-vitamins were taken. FOR OFFICE USE ONLY: Coordinators are required to check "no" or "yes" as to whether the selections to the above items were verified by the containers if the person takes multi-vitamins. If the person does not take multi-vitamins then this question is not applicable. 2. If the patient has taken any other vitamins (on reported in the above question) in the past 90 days, this time should be checked "yes." If not, the patient should skip to the next question.

	2.1 If the patient takes other vitamins in the past 90 days, the patient should check yes or no as to whether or not the vitamins were iron, folate, calcium, vitamin D, vitamin B12. Also, for each vitamin reported as "yes" the patient should report whether they are "no longer taking them" if they are being taken daily (defined as 1 or more times per day), weekly (defined as 1 – 6 times per week), Monthly/rarely, (defined as 0-3 time per month). FOR OFFICE USE ONLY: Coordinators are required to check "no" or "yes" as to whether the selections to the above items were verified by the containers if the person takes multi-vitamins. If the person does not take other vitamins then this question is not applicable. In addition, patient are required to report whether or not they are using vitamin B12 injections and whether or not the injections are being administered monthly, every other month or every 3 months. 3. If the patient has taken pain medication, prescription or over-the-counter, for their back, hip, knee(s) or ankle(s), the item should be marked "yes" otherwise "no." For each item marked "yes," the number of days the medication was taken IN THE PAST WEEK should be entered. 4. If the patient has taken prescription or over-the-counter medication for acid reflux, heartburn or haital hernia, this item should be marked "yes" otherwise marked "no." If the patient marks this item "yes" then the patient must record the number of days that this medication was taken in the last week. 5. If the patient has taken any low-dose aspirin (such as baby aspirin or one regular strength aspirin tablet) for reason other than for pain, **such as to prevent heart attack or strok**e, this item should be marked "yes" otherwise "no." If the patient marks this item "yes" then the patient must record the number of days that this medication was taken in the last week.

	6.	If the patient has taken any prescription medication (defined as being prescribed by the patient's doctor) this item should be marked "yes" otherwise "no." If the patient marks this item "yes" then the patient should clearly print the name, as listed on the medication bottle/container, each of the prescription medication that has been taken in the past 90 days and how often they are being taken. No longer taking is defined as the patient has been prescribed the medication in the past 90 days but is no loner taking it. Daily is defined as 1 or more times/day. Weekly is defined as 1 to 6 times per week. Monthly or Rarely is defined as 0 to 3 time per month. FOR OFFICE USE ONLY: Coordinators are required to check "no" or "yes" as to whether each of the medication entries were verified by the containers. If the person does not take prescription medication, then this question is not applicable.