Concomitant Medication

Patient No.: __ __ __

Date of birth: _ _ . _ _ . _ _ _ _ (DD/MM/YYYY)

Date of diagnosis: _ _ . _ _ . _ _ _ _ (DD/MM/YYYY)

Please list all medications and significant non-drug therapies, which were taken 2 weeks before study begin.

Please make a separate entry for each change in dosage regimen or route.

Generic Name (use trade name if possible)	Indication	Single dose	Unit	Frequency	Start date (DD/MM/YYYY)	End date (DD/MM/YYYY)	Route	AE 1 = yes 2 = no	No. AE
					_ _ . _ _ . _ _ _ _	_ _ . _ _ . _ _ _ _ ☐ ongoing			
					_ _ . _ _ . _ _ _ _	_ _ . _ _ . _ _ _ _ ☐ ongoing			
					_ _ . _ _ . _ _ _ _	_ _ . _ _ . _ _ _ _ ☐ ongoing			
					_ _ . _ _ . _ _ _ _	_ _ . _ _ . _ _ _ _ ☐ ongoing			
					_ _ . _ _ . _ _ _ _	_ _ . _ _ . _ _ _ _ ☐ ongoing			

Route

1 = oral	4 = intravenous (i.v.)	7 = nasal	88 = other (specify)
2 = subcutaneous (s.c.)	5 = rectal	8 = inhalated	99 = not applicable
3 = intramuscular (i.m.)	6 = topical	9 = transdermal	

DATE (DD/MM/YYYY)	**NAME** (READABLE!)	**SIGNATURE**	**HOSPITAL** (STAMP)
_ _ . _ _ . _ _ _ _	________________	________________	