A3.9 CONCOMITANT MEDICATIONS / DRUGS (PAGE ONE)

This is to be completed at each visit. Prompt questions include: Has (*participant*) seen a doctor since my last visit? Has (*participant*) stopped any of the following medications? Has (*participant*) changed the dose of any of the following medications? Has (*participant*) started any new medications?

Name of Medication (Brand or Generic)	**Date Started (dd/mm/yyyy)**	**Date Stopped (dd/mm/yyyy)**	**Total Daily Dose**	**Units**	**Indication /Reason**	**Staff Initials & Date**	**Continuing**