Subject ID \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / (MM/DD/YYYY)

Please list ALL medications (including prescription drugs, over the counter drugs, dietary supplements (including vitamins), herbal, homeopathic and health food preparations) taken routinely or in the last four weeks.

|  | **Medication/ supplement name** | **Dose/Units** | **Route of Administration.** | **Prescribed dosing schedule** | **Taking since when?** | **Actual usage schedule (Write “same” or write how often you are actually taking)** | **Condition you are taking the medication for** | **If this medicine was prescribed for your ME/CFS, list symptoms that the medicine has improved, and list those (if any) the medicine has made worse. If medicine not prescribed for ME/CFS, write “NA” (not applicable)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Example | **Aspirin** | **81 mg** | **oral** | **1 pill each am** | Jan 2009 |  | **Prevention of heart problems** | **NA** |
| Example | **Vitamin D** | **1000 IU** | **oral** | **1 pill each pm** | Sep 2010 |  | **Prevention of osteoporosis** | **NA** |
| Example | **Gabapentin** | **300 mg** | **oral** | **1 pill 2x/day** | Jun 2012 |  | **Improve nerve pain and fatigue** | **Improved pain; thinking worse** |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  |  |  |
| 19 |  |  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Examples of Routes**  **Of Administration** |  | **Examples of dosing schedules** | | |
| By mouth | By suppository | Every night at bedtime | 3x a day | Every morning |
| By injection | By enema | Twice a day | 4x a day | Every evening |
| By skin patch |  | As needed |  |  |

**Other Treatments**

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Date(s) When Treated** | **Result of Treatment (circle one)** |
| Dietary changes |  | Helped/ Hurt/ No effect |
| Cognitive behavioral therapy |  | Helped/ Hurt/ No effect |
| Graded exercise therapy |  | Helped/ Hurt/ No effect |
| Pacing |  |  |
| Other (Specify): |  | Helped/ Hurt/ No effect |