## Currently Taking Prescription Medications? No Yes Unknown

## Type of Prescription Medications (check all that apply)

## Anti-Depressant

If checked, indicate type:

## Anti-Anxiety

If checked, indicate type:

## Anti-Psychotic

If checked, indicate type:

## Migraine

## If checked, indicate type

## Anti-seizure

If checked, indicate type:

## Cardiovacular

If checked, indicate type:

## Diabetes

If checked, indicate type:

## Narcotic Pain Medication

If checked, indicate type:

## Non-Narcotic Pain Medication

If checked, indicate type:

## Sleep Aid/Sedative

If checked, indicate type:

## Psychostimulant (ADHD)

If checked, indicate type:

## Birth Control

If checked, indicate type:

## Allergy

If checked, indicate type:

## Asthma

If checked, indicate type:

## Acid Reflux/Heart Burn

If checked, indicate type:

## Other

If checked, indicate type:

## Are you currently taking any over-the-counter medications (eg Advil/ibuprofen, Claritin, etc)? Yes No (Either today or on a regular basis)

## Type of over-the-counter medicine

## Advil/ibuprofen Tylenol/Acetaminophen Claritin/Allergy medication Other

## Other OTC, what?

## Are you currently taking any over-the-counter supplements (eg protein or vitamins)?

## Yes No (Either today or on a regular basis)

## Type of over-the-counter supplement

## Protein Creatine DHEA Chromium Androstenedione Vitamins Weight Loss Other

## 

Questions from other NINDS CDEs:

Did the patient/participant take any medications: XX days before or during the study?  Yes  No(If “No”, leave rest of form blank)

Table 1 Concomitant Medications

| Medication Name  (Trade or generic name) | Indication  (If given for AE, enter exact term from AE CRF) | Dose | Dose Units | Frequency | Route1 | Start Date  (mm/dd/yyyy) | End Date  (mm/dd/yyyy) | Ongoing? |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TBD | TBD | TBD | TBD | TBD | TBD | MM/DD/YYYY | MM/DD/YYYY | Yes  No |

Add more rows as needed

1Select from the following for medication route: Buccal, Inhaled, Intramuscular, Intravenous, Nasal, Oral, Rectal, By ear, Topical, Subcutaneous, Sublingual, Transdermal, Unknown, Other/Specify.

For specific medication questions related to the neurological, genitourinary, gastrointestinal or cardiovascular system, please see the Exploratory list of questions which may be applicable.

## Additional Exploratory Elements (as applicable):

1. Any steroids administered2:

Methylprednisone/Corticosteriods: (at any point during their stay):

NASCIS II (Methylprednisolone or Solumedrol run as an infusion x 23 or 24 hrs)

NASCIS III (Methylprednisolone or solumedrol run as an infusion x 47 or 48 hrs)

Other, specify

None

Unknown

Date administered: YYYYMMDD2

1. Any vasopressor use2

No

Yes

Unknown

Assessment date: YYYYMMDD2

1. Any drugs for the urinary tract within the last year2:

No

Yes, bladder relaxant drugs (anticholinergics, tricyclic antidepressants, etc.)

Yes, sphincter/bladder neck relaxant drugs (alpha adrenergic blockers, etc.)

Yes, antibiotics/antiseptics:

For treatment of urinary tract infection

For prophylactic reasons

Yes, other, specify

Unknown

Assessment date: YYYYMMDD

1. Medication affecting bowel function / constipating agents (within the last four weeks) 2:

No

Yes, anticholinergics

Yes, narcotics

Yes, other, specify:

Unknown

Assessment date: YYYYMMDD

1. Medication affecting bowel function - oral laxatives (within the last four weeks)2:

No

Yes, osmotic laxatives (drops)

Yes, osmotic or bulking laxatives (tablets or granulates)

Yes, irritant laxatives (drops)

Yes, irritant laxatives (tablets)

Yes, prokinetics

Yes, other, specify:

Unknown

Assessment date: YYYYMMDD

1. Any medication affecting cardiovascular function on the day of examination2:

No

Yes, anticholinergics

Yes, antihypertensives (beta-blocker, ACE etc)

Yes, antihypotensives

Yes, cardiac (digitalis, anti-arrhythmics, etc)

Yes, other, specify

None of the above

Unknown

Assessment date: YYYYMMDD

1. Any treatment for spasticity/spasms within the last four weeks2:

No

Yes

Unknown

Assessment date: YYYY/MM/DD

## General Instructions

Important note: None of the data elements on this CRF Module are considered Core (i.e., strongly recommended for all sports-related concussion clinical studies to collect). They are supplemental and should only be collected if the research team considers them appropriate for their study.

## Specific Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*