## 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.*