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OMB#: 0925-0585
Exp. xx/xx/xxxx

HCHS/SOL- Visit 2- Medication Use Survey

ID NUMBER:

FORM CODE: MSE
VERSION: 1, 12/10/13

Contact Occasion

0 2

SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. Use the CDART Notelog window to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.

Reported medication use for specified conditions (Add to medical Hx. Questionnaire)

I. Medication Use Interview

Now I would like to ask about a few specific medications.

1. Were any of the medications you took during the **last four weeks** for:

- | | | | |
|--|---|--------------------------------|------------------------------------|
| a. Asthma | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| a1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| b. Chronic bronchitis or emphysema | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| b1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| c. High blood sugar or diabetes | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| c1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| d. High blood pressure or hypertension | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| d1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| e. High blood cholesterol | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| e1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| f. Chest pain or angina | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| f1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| g. Abnormal heart rhythm | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| g1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |
| h. Heart failure | No 0 <input type="checkbox"/> | Yes 1 <input type="checkbox"/> | Unknown 9 <input type="checkbox"/> |
| h1. How long have you been taking this medication? | <input type="checkbox"/> < 1 year, <input type="checkbox"/> 1-5 years, <input type="checkbox"/> > 5 years | | |

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02 SEQ #

- i. Blood thinning No 0 Yes 1 Unknown 9
i1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- j. Stroke No 0 Yes 1 Unknown 9
j1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- k. Mini-stroke or TIA No 0 Yes 1 Unknown 9
k1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- l. Leg pain while walking or claudication No 0 Yes 1 Unknown 9
l1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- m. Depression No 0 Yes 1 Unknown 9
m1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- n. Anxiety No 0 Yes 1 Unknown 9
n1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- o. Glaucoma No 0 Yes 1 Unknown 9
o1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years
- p. A disease of the thyroid No 0 Yes 1 Unknown 9
p1. How long have you been taking this medication? < 1 year, 1-5 years, > 5 years

2. During the last four weeks, did you take any aspirin or aspirin-containing products including Alka-Seltzer, cold and allergy medication or headache powder? This **excludes** acetaminophen (for example, Tylenol), ibuprofen (for example, Advil, Motrin or Nuprin), and naproxen (for example, Aleve).

Show participant List #1: Commonly Used Aspirin or Aspirin-Containing Products

- No 0 → **GO TO QUESTION 5**
Yes 1
Unknown 9 → **GO TO QUESTION 5**

3. How many days during the last four weeks did you take aspirin or aspirin-containing medication?

Number of days If number of days equals "00" → **GO TO QUESTION 5**

4. For what purpose are you taking aspirin? (Interviewer: **Do NOT** read choices.)

- Participant mentioned avoiding heart attack or stroke 1
Participant did not mention avoiding heart attack or stroke 2

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SEQ #		
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5. During the past four weeks, did you take any [other] medication for arthritis, fever, or muscle aches and pains, or cramps? (*Read bracketed "other" unless no medications were reported.*)

- No 0
Yes 1
Unknown 9

6. **Excluding** aspirin, acetaminophen (for example, Tylenol), and corticosteroids (for example prednisone), are you NOW taking other anti-inflammatory or arthritis medications on a regular basis? Common examples are shown on this list.

Show participant List #2: Commonly Used Non-Steroidal Anti-Inflammatory Drugs, NSAIDS

- No 0 → **END QUESTIONNAIRE**
Yes 1
Unknown 9 → **END QUESTIONNAIRE**