



Trials of Hypertension Prevention
(TOHP), supported by the National
Heart, Lung, and Blood Institute,
National Institutes of Health

Visit _____
ID number _____
Initials _____
Visit date ____/____/____

PRESCRIPTION MEDICATION INFORMATION

The date when you last provided information regarding your medication use was ____/____/____

1. Since you last provided information, have you regularly used prescription drugs? (IF YES: Please list below.)

	Currently Using?		Month/Year Started	NO <input type="checkbox"/>	If <i>Not</i> Currently Using Month/Year Stopped
	YES	NO		<input type="checkbox"/>	
a. _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	____/____/____
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	____/____/____
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	____/____/____
d. _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	____/____/____
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	<input type="checkbox"/>	____/____/____

STAFF USE

IF NO DRUGS TAKEN, SKIP TO ITEM #4

2. Are any of the medications listed in item #1 antihypertensive agents or medications that affect blood pressure (code 01, 02, or 03)? YES (1) NO (2)

IF YES: Is the participant CURRENTLY using the medication? YES (1) NO (2)

3. Do these medications (listed in item #1) indicate that the intervention should be discontinued? YES (1) NO (2)

4. TOHP identification number of person completing this form

5. TOHP identification number of person editing this form

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