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- FORM:** 153 – MEDICATION AND SUPPLEMENT INVENTORY
- Version:** 1 – July, 2009
- Description:** Self-administered or interviewer-administered; 9-page booklet; key-entered at the Clinical Coordinating Center (CCC).
- When used:** Collected one time as part of the annual contacts for Clinical Trial (CT) and Observational Study (OS) participants enrolled in the WHI Extension Study.
- Purpose:** To collect updated information on the prescription and over-the-counter medications and nutritional supplements currently being used by participants.
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### GENERAL INSTRUCTIONS

1. The form is printed in both English (*Form 153*) and Spanish (*Form 153S*) versions.
2. The *Form 153* for WHI Extension Study participants will be labeled and mailed from the CCC directly to the participant. The *Form 153* will be included in the routine annual CCC mailing.
  - The CCC mails the form to the participant and asks her to mail it back in a return envelope by a specified date. Following the CCC mailing, if the participant does not return the *Form 153* within 3 months of the first mailing, it will be sent again. If the form is not returned within 2 months of the second mailing, the form will be sent a third time. If the form is still not returned, CCC staff will contact the participants by telephone to collect the information from willing participants. The CCC will data enter the forms, and will use the Medispan database to code medications during the data entry process.
3. In the event that this form is collected by FC staff, the form should be sent to the CCC for data entry.

### Item Instructions

#### Cover page

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|----|---------------|---|
| 1. | Date Received | Fill in date received at the CCC.   |
| 2. | Reviewed By   | Fill in standard 3-digit WHI employee ID of staff member reviewing the form for data entry. |
| 3. | Contact Type  | Mark appropriate box (phone, mail, other).  |

#### Prescription Medications

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|-----|---|--|
| 1.  | Currently Taking Prescription Medications | No/Yes. Participants indicating “No” skip to Q 4 in Section B.   |
| 2a. | Prescription Medication Name              | For each prescription medication listed, participant records the name of the medication.   |
| 2b. | Prescription Medication Strength          | For each prescription medication listed, participant records the strength of the medication.   |
| 2c. | Prescription Medication Type              | For each prescription medication listed, participant records the medication type, e.g., capsule, tablet, cream, liquid, suppository, inhaler, injection.   |
| 2d. | Prescription Medication Duration          | For each prescription listed, participant indicates length of time taking medication. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 provide the actual number of years. |

Repeat 2a-d for each prescription medication, up to 10 medications.

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|----|--------------------------------------|--|
| 3. | Other Prescription Medications       | Participant records name of any other prescription medications they are taking, if there was not enough room to list them in item 2 above. |
| 4. | Barriers to Prescription Medications | Participant checks all barriers that apply.  |

#### Non-Prescription Medications

Participant indicates the following information for each of these non-prescription medications: aspirin, anti-inflammatory, antacid or heartburn medicines, and natural female hormones. Participants can list up to 2 types of anti-inflammatory, antacids, and natural hormones.

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| 5. | Taken the Non-Prescription Medication in Past Two Weeks | Yes/No. Participants indicating “No” skip to the next non-prescription medication.   |
| 5. | Name of the Non-Prescription Medication                 | For each medication they are taking, participant provides the name of the product.   |
| 5. | Strength of the Non-Prescription Medication             | For each medication they are taking, participant provides the strength of the product.   |
| 5. | Non-Prescription Medication – Frequency                 | For each medication they are taking, participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week; 5. 1-3 days a month.  |
| 5. | Prescription Medication Duration                        | For each medication they are taking, participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years. |

6. Over-the-Counter Insulin Participants are asked if they are taking over-the-counter insulin Yes/No. Those who indicate yes, are asked to provide the name of the product, the strength, how often it is taken (1. Once a day or more; 2. Less than once a day) and how long it has been taken (1. Less than a month; 2. 1-12 months; 3. More than 1 year. How many years?)

### Dietary Supplements

- 7 M/V. Daily Multi-Vitamin Supplement – Taken in Past 2 Weeks Yes/No. Participants indicating “No” skip to the next supplement.
- Daily Multi-Vitamin Supplement – Product Name Participant provides the name of the product.
- Daily Multi-Vitamin Supplement – Frequency Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
- Daily Multi-Vitamin Supplement – Duration Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.
- 7 Cal/VitD. Calcium/Vitamin D Supplementation Mixture – Taken in Past 2 Weeks Yes/No. Participants indicating “No” skip to the next supplement.
- Calcium/Vitamin D Supplementation Mixture – Product Name Participant provides the name of the product.
- Calcium/Vitamin D Supplementation Mixture – Strength Participant provides strength of calcium and strength of vitamin D.
- Calcium/Vitamin D Supplementation Mixture – Frequency Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
- Calcium/Vitamin D Supplementation Mixture – Duration Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.
- 7 Cal. Calcium Single Supplement – Taken in Past 2 Weeks Yes/No. Participants indicating “No” skip to the next supplement.
- Calcium Single Supplement – Product Name Participant provides the name of the product.
- Calcium Single Supplement - Strength Participant provides strength of calcium.
- Calcium Single Supplement – Frequency Participant indicates how often they take it. The options are: 1. Once a day or more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
- Calcium Single Supplement – Duration Participant indicates how long they have been taking it. Response choices are: 1. Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response 3 also indicate the actual number of years.

- 7      Vitamin D Single      Yes/No. Participants indicating “No” skip to the next supplement.  
VitD. Supplement – Taken in  
Past 2 Weeks
- Vitamin D Single      Participant provides the name of the product.  
Supplement – Product  
Name
- Vitamin D Single      Participant indicates strength of the vitamin D.  
Supplment - Strength
- Vitamin D Single      Participant indicates how often they take it. The options are: 1. Once a day or  
Supplement – Frequency      more; 2. 4-6 days a week; 3. 2-3 days a week; 4. Once a week.
- Vitamin D Single      Participant indicates how long they have been taking it. Response choices are: 1.  
Supplement – Duration      Less than a month; 2. 1-12 months; 3. More than 1 year. Those indicating response  
3 also indicate the actual number of years.
8.      Date      Month/Day/Year the form was completed.