Prior and Concomitant Medications

STUDY NAME

Site Number: ______________________

Pt_ID: ______________________

Were any concomitant medications taken by the participant __ days before or during the study? Yes (If so record below) ☐ No ☐

Medication	Indication	Start Date (dd/mmm/yyyy)	Stop Date (dd/mmm/yyyy)	Ongoing
1.				☐
2.				☐
3.				☐
4.				☐
5.				☐