EDITORIAL NOTE: These medications are specifically for digestive problems.

STUDY OF DIGESTIVE HEALTH

SECTION E. MEDICATION HISTORY

The next section of questions asks about a variety of prescription and over-the-counter medications (you/your_____) may have taken. We are interested only if (you/s/he) took these drugs before a year ago. Please try to think only about this time when answering these questions.

E1. Here is a list of some prescription medications taken for ulcers, heartburn, and other stomach problems. Please look over the list. Before a year ago, did (you/your _____) ever take any of them at least once a week for one month or longer?

SHOW CARD E1

YES 1
NO 2 (E7)
DK 8 (E7)

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

E2. Which of these medications (have you/has your _____/had your _____) taken at least once a week for one month or longer?

SHOW CARD E1

BRAND NAMES		GENERIC NAMES	
Axid (AK-sid)	01	nizatidine (ni-ZA-ti-deen)	09
Carafate (CARE-a-fate)	02	sucralfate (SOO-cral-fate)	10
Cytotec (SI-tow-tec)	03	misoprostol (mi-zo-PRO-stall)	11
Losec (LO-sec)	04	omeprazole (oh-ME-pra-zall)	12
Prilosec (PRI-lo-sec)	05	famotidine (fam-AH-ti-deen)	13
Pepcid (PEP-sid)	06	cimetidine (si-MED-deen)	14
Tagamet (TAG-a-met)	07	ranitidine (ran-IH-ti-deen)	15
Zantac (ZAN-tac)	08		

WRITE THE NUMBER AND NAME OF EACH MEDICATION RESPONDENT REPORTED IN E2, THEN ASK E3-E6 FOR EACH OF THESE MEDICATIONS.

E2. MEDICATION CODE NUMBER	E2. MEDICATION NAME	E3. When did (you/your___) start taking (MEDICATION)?	E4. When did (you/your___) stop taking (MEDICATION)?	E5. Before a year ago, for how many months or years, in total, did (you/s/he) take (MEDICATION)?	E6. How often did (you/s/he) usually take (MEDICATION)?
a. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
b. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
c. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
d. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF EARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
e. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
f. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
g. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98
h. |__|__|		|__|__| AGE OR YEAR DK ……98	|__|__| AGE OR YEAR CURRENTLY…95 DK …….. 98	|__|__| MONTHS..1 # OF YEARS..2 DK …….. 98	|__|__| DAY .....1 TIMES WEEK ...2 PER MONTH.3 DK …….. 98

E7. Here is a group of some additional prescription medications taken for ulcers, heartburn, and other reasons. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week for six months or longer?

SHOW CARD E2

YES 1
NO 2 (E13)
DK 8 (E13)

E8. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E2

BRAND NAMES
Bentyl (BEN-till) 01
Donnatal (DON-a-tall) 02
Librax (LI-brax) 03
Pro-Banthine (pro-BAN-theen) 04
Robinul (RO-bin-ull) 05

GENERIC NAMES
dicyclomine (di-SI-clo-meen) 06
propantheline (pro-PAN-thi-leen) 07
glycopyrrolate (gli-co-PEER-o-late) 08

E9. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E10. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E11. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| MONTHS 1
OF YEARS 2
DK 98

E12. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| PER DAY 1
TIMES WEEK 2
MONTH 3
DK 98

E13. Here is a group of some over-the counter medications taken for ulcers, heartburn, and other reasons. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E3

YES 1
NO 2 (E18)
DK 8 (E18)

SHOW CARD E3

BRAND NAMES Any type or strength of:			
Digel	01	Mylanta	06
Gaviscon	02	Riopan	07
Gelusil	03	Rolaids	08
Maalox	04	Tums	09
Milk of Magnesia	05	Any <u>other</u> over-the-counter antacid	99

E14. When did (you/s/he) start taking any of these medications?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E15. When did (you/s/he) stop taking any of these medications?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E16. Before a year ago, for how many months or years, in total, did (you/s/he) take any of these medications?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E17. How often did (you/your _____) usually take any of these medications?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E18. Before a year ago, did (you/your _____) ever take Pepto-Bismol at least once a week for six months or longer?

YES 1
NO 2 (E23)
DK 8 (E23)

E19. When did (you/s/he) start taking Pepto-Bismol?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E20. When did (you/s/he) stop taking Pepto-Bismol?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E21. Before a year ago, for how many months or years, in total, did (you/s/he) take Pepto-Bismol?

|__|__| MONTHS 1
OF YEARS 2
DK 98

E22. How often did (you/your _____) usually take Pepto-Bismol?

|__|__| PER DAY 1
TIMES WEEK 2
MONTH 3
DK 98

E23. Here is a group of some prescription medications taken for high blood pressure or heart problems. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E4

YES 1
NO 2 (E29)
DK 8 (E29)

E24. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E4

BRAND NAMES
Adalat (A-da-lat) 01
Procardia (pro-CAR-dee-a) 02
Calan (KAY-lan) 03

Isoptin (i-SOP-tin) 04
Verelan (VER-e-lan) 05
Cardene (CAR-deen) 06
Cardizem (CAR-di-zem) 07
Dynacirc (DYE-na-sirk) 08
Nimotop (NIM-o-top) 09
Norvasc (NOR-vask) 10
Plendil (PLEN-dill) 11
Vascor (VASK-or) 12

GENERIC NAMES
nifedipine (ni-FE-di-peen) 13

verapamil (ver-A-pam-ill) 14
nicardipine (ni-CAR-di-peen) 15
diltiazem (dil-TE-a-zem) 16
isradipine (is-RA-di-peen) 17
nimodipine (nim-O-di-peen) 18
amlodipine (am-LO-di-peen) 19
Felodipine (fell-O-di-peen) 20
bepridil (BE-pri-dill) 21

E25. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E26. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E27. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E28. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E29. Here is a second group of prescription medications taken for heart problems. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E5

YES 1
NO 2 (E35)
DK 8 (E35)

E30. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E5

BRAND NAMES
Isordil (I-sor-dill) 01
Sorbitrate (SOR-bi-trate) 02
Nitro-Bid (NI-tro-bid) 03
Nitrospan (NI-tro-span) 04
Nitrostat (NI-tro-stat) 05
Nitrodisc (NI-tro-disk) 06
Nitro-Dur (NI-tro-dur) 07
Transderm-Nitro (TRANS-derm-NI-tro) ..08

GENERIC NAMES
isosorbide dinitrate (i-so-SOR-bide di-NYE-trate) 09
nitroglycerin tablets/capsules (ni-tro-GLIH-ser-in) 10
nitroglycerin patch (ni-tro-GLIH-ser-in) 11

E31. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E32. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E33. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E34. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E35. Before a year ago, did (you/your _____) ever take Norpace at least once a week for six months or longer?

YES 1
NO 2 (E40)
DK 8 (E40)

E36. When did (you/s/he) start taking Norpace?

|___|___| AGE OR |___|___|___|___| YEAR
DK 98

E37. When did (you/s/he) stop taking Norpace?

|___|___| AGE OR |___|___|___|___| YEAR
CURRENTLY 95
DK 98

E38. Before a year ago, for how many months or years, in total, did (you/s/he) take Norpace?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E39. How often did (you/your _____) usually take Norpace?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E40. Here is another group of prescription medications taken for high blood pressure or heart problems. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E6

YES 1
NO 2 (E46)
DK 8 (E46)

E41. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E6

BRAND NAMES	
Kaon (KAY-on)	01
K-Dur (KAY-dur)	02
K-Tab (KAY-tab)	03
Micro-K (MI-cro-kay)	04
Slow-K (SLOW-kay)	05

GENERIC NAMES	
potassium chloride (po-TASS-e-um-KLOR-ide)	06

E42. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

DK 98

E43. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

CURRENTLY 95

DK 98

E44. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF

MONTHS 1

YEARS 2

DK 98

E45. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER

DAY 1

WEEK 2

MONTH 3

DK 98

E46. Here is a group of some prescription medications taken for pain or inflammation. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E7

YES	1	
NO	2	(E52)
DK	8	(E52)

E47. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E7

BRAND NAMES	
Anaprox (AN-a-prox)	01
Naprosyn (NAP-row-sin)	02
Ansaid (AN-sed)	03
Butazolidin (bew-ta-ZOL-ih-din)	04
Clinoril (CLIN-o-rill)	05
Daypro (DAY-pro)	06
Dolobid (dol-O-bid)	07
Feldene (FELL-deen)	08
Indocin (IN-do-sin)	09
Lodine (LOW-deen)	10
Meclomen (MECK-low-men)	11
Nalfon (NAL-fon)	12
Orudis (or-OO-diss)	13
Relafen (re-LAF-fin)	14
Tolectin (to-LECK-tin)	15
Voltaren (vol-TARE-en)	16

GENERIC NAMES	
naproxen (na-PROCKS-in)	17
flurbiprofen (flur-bi-PRO-fen)	18
phenylbutazone (fee-nill-BYEW-ta-zone)	19
sulindac (SOO-lin-dack)	20
oxaprozin (ocks-a-PRO-zin)	21
diflunisal (di-FLOON-i-zall)	22
piroxicam (pi-ROCKS-i-cam)	23
indomethacin (in-do-METH-a-sin)	24
etodolac (e-TOW-doe-lack)	25
meclofenamate (meck-lo-FEN-a-mate)	26
fenoprofen (fee-no-PRO-fen)	27
ketoprofen (kee-to-PRO-fen)	28
nabumetone (nah-BYEW-ma-tone)	29
tolmetin (TOLL-met-in)	30
diclofenac (di-CLO-fen-ack)	31

E48. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

DK 98

E49. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

CURRENTLY 95

DK 98

E50. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF

MONTHS 1

YEARS 2

DK 98

E51. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER DAY 1
WEEK 2
MONTH 3
DK 98

E52. Here is a group of some over-the-counter medications that contain aspirin and are taken for pain or inflammation. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E8

YES 1
NO 2 (E57)
DK 8 (E57)

SHOW CARD E8

BRAND NAMES
Any type or strength of aspirin-containing medications, such as:

Anacin 01
Aspirin 02
Ascriptin 03
Bufferin 04
Excedrin 05
Any other kind of aspirin-containing product not listed here 99

Please do not include drugs containing only acetaminophen, such as Tylenol, Excedrin PM, Aspirin-Free Anacin, etc.

E53. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
DK 98

E54. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
CURRENTLY 95
DK 98

E55. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF MONTHS 1
YEARS 2
DK 98

E56. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER DAY 1
WEEK 2
MONTH 3
DK 98

E57. Here is a group of over-the-counter medications that contain ibuprofen and are taken for pain or inflammation. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E9

YES 1
NO 2 (E62)
DK 8 (E62)

SHOW CARD E9

BRAND NAMES	
Advil 01	Nuprin 04
Medipren 02	Rufen 05
Motrin 03	Generic ibuprofen 06

E58. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
DK 98

E59. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
CURRENTLY 95
DK 98

E60. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E61. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E62. Here is a group of some prescription medications taken for depression, anxiety or insomnia. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E10

YES 1
NO 2 (E68)
DK 8 (E68)

E63. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E10

BRAND NAMES	
Asendin (a-SEN-din)	01
Aventyl (a-VEN-till)	02
Pamelor (PAM-a-lor)	03
Elavil (ELL-a-vill)	04
Endep (EN-dep)	05
Ludiomil (LOO-dee-o-mill)	06
Sinequan (SIN-e-quan)	07
Surmontil (sur-MON-till)	08
Tofranil (TOF-ran-ill)	09
Vivactil (vi-VACK-till)	10

GENERIC NAMES	
amoxipine (am-OCKS-i-peen)	11
nortriptyline (nor-TRIP-ti-leen)	12
amitriptyline (am-ih-TRIP-ti-leen)	13
maproteline (ma-PRO-te-leen)	14
doxepin (DOCKS-i-pin)	15
trimipramine (trim-IP-ra-meen)	16
imipramine (im-IP-ra-meen)	17
protriptyline (pro-TRIP-ti-leen)	18

E64. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

DK 98

E65. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

CURRENTLY 95

DK 98

E66. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF

MONTHS 1

YEARS 2

DK 98

E67. How often did (you/your _____) <u>usually</u> take (this medication/any of these medications)?

|__|__| TIMES PER

DAY 1

WEEK 2

MONTH 3

DK 98

E68. Here is a group of some <u>prescription</u> medications taken for asthma. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

<u>SHOW CARD E11</u>

YES	1	
NO	2	(E74)
DK	8	(E74)

E69. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E11

BRAND NAMES	
Alupent (AL-yew-pent)	01
Metaprel (MET-a-prel)	02
Brethaire (BRETH-aire)	03
Brethine (BRETH-een)	04
Bricanyl (BRI-can-ill)	05
Bronkometer (BRON-koe-mee-ter)	06
Bronkosol (BRON-koe-sol)	07
Isuprel (EYE-soo-prel)	08
Maxair (MAX-air)	09
Proventil (pro-VEN-til)	10
Ventolin (VENT-o-lin)	11
Tornalate (TOR-na-late)	12

GENERIC NAMES	
metaproterenol (met-a-PRO-ter-en-ol)	13
terbutaline (ter-BYEW-ta-leen)	14
isoetharine (i-so-ETH-a-reen)	15
isoproterenol (i-so-PRO-ter-en-ol)	16
pirbuterol (per-BYEW-ter-ol)	17
albuterol (al-BYEW-ter-ol)	18
bitolterol (bi-TOL-ter-ol)	19

E70. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

DK 98

E71. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

CURRENTLY 95

DK 98

E72. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF MONTHS 1

YEARS 2

DK 98

E73. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER DAY 1

WEEK 2

MONTH 3

DK 98

E74. Here is another group of some prescription medications taken for asthma. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E12

YES 1

NO 2 (E80)

DK 8 (E80)

E75. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E12

BRAND NAMES
Aerolate (AIR-o-late) 01
Asbron (AS-bron) 02
Constant-T (CON-stant-T) 03
Marax (MAR-acks) 04
Quadrinal (QUA-drin-all) 05
Quibron (QUI-bron) 06
Theodur (THEE-o-dur) 07
Aminophyllin (a-meen-O-fill-in) 08
Atrovent (A-tro-vent) 09
Choledyl (CO-le-dill) 10
Dilor (DI-lore) 11
Lufyllin (loo-FILL-in) 12
Respbid (RES-bid) 13
Slo-Bid (SLOW-bid) 14
T-PHYL (TEE-fill) 15
Tedral (TE-drall) 16
Theo-24 (THEE-o-24) 17
Theobid (THEE-o-bid) 18
Theolair (THEE-o-lare) 19
Theo-Organdin (THEE-o-or-GAN-din) 20
Uniphyl (EW-ni-fill) 21

GENERIC NAMES
theophylline (thee-O-fi-lin) 22
aminophylline (a-min-O-fi-lin) 23
ipratropium bromide (i-pra-TROP-e-um-BRO-mide) 24
oxtriphylline (ocks-TRI-fi-leen) 25
dyphylline (DI-fi-leen) 26
anhydrous theophylline (an-HI-drus-thee-O-fi-lin) 27

E76. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
DK 98

E77. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR
CURRENTLY 95
DK 98

E78. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E79. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98

E80. Here is a group of some over-the-counter medications taken for asthma. Thinking of these medications as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E13

YES	1	
NO	2	(E86)
DK	8	(E86)

E81. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E13

BRAND NAMES	
Asthmahaler Mist (AS-ma-hale-er-MIST)	01
Asthmanefrin (as-ma-NEF-rin)	02
Bronkaid Mist (BRONK-ade-MIST)	03
Bronkaid Tablets (BRONK-ade-TAB-lets)	04
Bronkolixir (bronk-o-LIX-er)	05
Bronkotabs (BRONK-o-tabs)	06
Primatene Mist (PRY-ma-teen-MIST)	07
Primatene Tablets (PRY-ma-teen-TAB-lets)	08

E82. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

DK 98

E83. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| AGE OR |___|___|___|___| YEAR

CURRENTLY 95

DK 98

E84. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF

MONTHS 1

YEARS 2

DK 98

E85. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER

DAY 1

WEEK 2

MONTH 3

DK 98

E86. Here is a group of some prescription and over-the-counter medications taken for allergies. Thinking of these drugs as a group, before a year ago, did (you/your _____) take any of them at least once a week, for six months or longer?

SHOW CARD E14

YES 1

NO 2

DK 8

E87. Which of these medications did (you/your _____) take?

DO NOT READ LIST UNLESS NECESSARY. FOR EACH MEDICATION REPORTED, CIRCLE THE CORRESPONDING CODE BELOW.

SHOW CARD E14

BRAND NAMES
Actidil (ACK-ti-dill) 01
Atarax (AT-ar-acks) 02
Vistaril (VIH-sta-rill) 03
Benadryl (BEN-a-drill) 04
Chlor-Trimeton (clor-TRI-me-ton) 05
Teldrin (TELL-drin) 06
Dimetane (DI-me-tane) 07
Phenergan (FEN-er-gan) 08
Ploaramine (PLOR-a-meen) 09
Tavist (TA-vist) 10
Temaril (TEM-a-rill) 11

GENERIC NAMES
triprolidine (tri-PRO-li-deen) 12
hydroxyzine (hi-DROCKS-i-zeen) 13
diphenhydramine (di-fen-HI-dra-meen) 14
chlorpheniramine (clor-fen-EER-a-meen) 15
brompheniramine (brom-fen-EER-a-meen) ..16
promethazine (pro-METH-a-zeen) 17
dexchlorpheniramine (decks-clor-fen-EER-a-meen).....18
clemastine (CLEM-a-steen) 19
trimeprazine (tri-MEP-ra-zeen) 20

E88. When did (you/s/he) start taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
DK 98

E89. When did (you/s/he) stop taking (this medication/any of these medications)?

|___|___| OR |___|___|___|___|
AGE YEAR
CURRENTLY 95
DK 98

E90. Before a year ago, for how many months or years, in total, did (you/s/he) take (this medication/any of these medications)?

|__|__| # OF
MONTHS 1
YEARS 2
DK 98

E91. How often did (you/your _____) usually take (this medication/any of these medications)?

|__|__| TIMES PER
DAY 1
WEEK 2
MONTH 3
DK 98