TOHP
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.) ..... NO ☐

	Currently Using? YES	Currently Using? NO	Month/Year Started	If *Not* Currently Using Month/Year Stopped	STAFF USE
a. _____	☐	☐	___ ___/___ ___	___ ___/___ ___	___ ___
b. _____	☐	☐	___ ___/___ ___	___ ___/___ ___	___ ___
c. _____	☐	☐	___ ___/___ ___	___ ___/___ ___	___ ___
d. _____	☐	☐	___ ___/___ ___	___ ___/___ ___	___ ___
e. _____	☐	☐	___ ___/___ ___	___ ___/___ ___	___ ___

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)

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4. TOHP identification number of person completing this form ..... ___ ___ ___ ___

5. TOHP identification number of person editing this form ..... ___ ___ ___ ___

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