

PILOT PARTUM: Medication

Site No.

Subject No.

### Concomitant Medication Form

Visit Type	Date of Visit	Delegate's Name	Delegate's Signature
<input type="checkbox"/> Baseline	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="checkbox"/> 6-week visit	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="checkbox"/> 90-day visit	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="checkbox"/> Unscheduled visit	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

NSAID Use Postpartum:  Yes  No

NSAID Name	Average Dose & Frequency	Date Started (dd/mmm/yyyy)	Date Stopped (dd/mmm/yyyy)	Ongoing at final visit?
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes

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**Other Medication Use:**       Yes       No      Includes prescriptions, vitamins, supplements, and over the counter medications.

Medication Name	Dose & Frequency	Date Started Postpartum (dd/mmm/yyyy)	Date Stopped (dd/mmm/yyyy)	Ongoing at final visit?
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes
				<input type="checkbox"/> Yes