OMB No. 0925-0522
Expiration Date: 7/31/2006

REPEAT: PAST 24 HOURS QUESTIONNAIRE

Please give your completed form to the EMSI examiner.

PLEASE COMPLETE ON DAY OF EXAMINER VISIT.

Instructions:

- Use the enclosed pen or any **DARK BLUE OR BLACK BALLPOINT PEN**.
- Mark only one answer for each question unless otherwise indicated.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

Fill in the bubbles COMPLETELY for each of the questions in this form.

Like this: ● Not like this: ⊗ ☑

If you must change an answer, please mark a single horizontal line through it and bubble in the correct answer completely.

Like this: ~~● YES~~ Not like this: ●✗ES

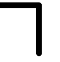
Please write responses in all capital letters and numbers without touching the sides of the boxes.

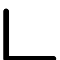
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example. EXAMPLE: June 7, 2004 = 0 6 / 0 7 / 2 0 0 4
(month) (day) (year)

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0522). Do not return the completed form to this address.





1. Date of repeat examiner visit: ☐☐ / ☐☐ / 2 0 ☐☐
(month) (day) (year)

2. How many different medications did you take in the last 24 hours? *(Please include all prescribed medications, including pills, patches, liquids, injections, inhalers, creams, etc. AND all non-prescribed or over-the-counter medications AND all vitamins and supplements.)*

(If you did not take any medications in the last 24 hours, fill in '00' and go to question 3.)

TOTAL NUMBER OF MEDICATIONS: ☐☐

2a. Copy the names off your medication bottles or packages directly to make sure that the spelling is correct. **Please do not include dosage or frequency of use.**

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

IF YOU TOOK MORE THAN 14 MEDICATIONS, PLEASE WRITE DOWN EACH MEDICATION ON A SEPARATE PIECE OF PAPER.

Please use a ballpoint pen for this form

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3. Have you had any alcoholic drinks (including wine, wine coolers, beer, and liquor) during the past 24 hours?

○ Yes →

4. How many alcoholic drinks have you had in the past 24 hours? *(A drink is equal to a 5-ounce glass of wine, one wine cooler, a 12-ounce bottle of beer, or one shot of liquor or one mixed drink.)*

NUMBER OF DRINKS: ☐☐

○ No

5. Have you smoked any cigarettes during the past 24 hours?

○ YES →

6. How many cigarettes have you smoked in the past 24 hours?

NUMBER OF CIGARETTES: ☐☐

○ NO

7. Please mark "YES" or "NO" for each of the following activities that you may have done <u>in the past 24 hours</u>.

Yes	No	In the past 24 hours, have you...
○	○	a. used any form of pesticides or bug repellent?
○	○	b. used solvents such as nail polish remover or paint thinner?
○	○	c. used hair spray, hair gel, or hair mousse?
○	○	d. used overnight cream, lotions, or self-tanners?
○	○	e. applied nail polish to your own or someone else's nails?
○	○	f. used perfume or cologne?
○	○	g. used makeup including foundation, blush, eye makeup, lipstick, etc.?
○	○	h. pumped your own gas?

8. Please mark "YES" or "NO" for each of the following activities that you may have done in the past week.

Yes	No	In the past week, have you...
⬭	⬭	a. had any medical procedures that required an IV (intravenous line), not including blood or platelet donation?
⬭	⬭	b. donated blood, not including platelet donation?
⬭	⬭	c. donated platelets, not including blood donation?
⬭	⬭	d. had major dental work, such as root canal, implants, gum surgery, etc.?
⬭	⬭	e. had routine dental work, such as cleanings, fillings, including crowns and x-rays?
⬭	⬭	f. had surgery on any area other than mouth?

Please use a ballpoint pen for this form

Please check to see that all questions are answered. Give this questionnaire to the EMSI examiner when she comes for your home visit.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

FOR OFFICE USE ONLY:
If this form was not completed by respondent, check here ☐

Initials: ☐☐☐ Date: ☐☐ / ☐☐ / 2 0 ☐☐
(month) (day) (year)