A-STAR: Concomitant Medication	
Patient Study ID: |___|___|___|___|___|___|	**Initials:** |___|___|___|

Current concomitant medication (for additional medications print further CRF pages)

\|___\|___\|

Medication name (**generic name**): _____

Dose and unit: _____

Frequency:

□ Once daily □ Weekly □ Unknown

□ Twice daily □ Alternate days □ Every month

□ Three times daily □ As needed □ Other

□ Four times daily

Reason: _____

Start date: \|___\|___\| \|___\|___\|___\| \|___\|___\|___\|___\|

Stop date: \|___\|___\| \|___\|___\|___\| \|___\|___\|___\|___\| *or* □ **Ongoing**

\|___\|___\|

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