

**HEALTHCARE PROVIDER BASELINE DATA FORM**IRB Approved at the
Protocol Level
Nov 08, 2023

Participant ID:

1. HEALTH CARE REPORTER

1.1 Date of Form Completion: month ____ day ____ year ____

1.2 Reporter Type:

- ☐ Patient ☐ Obstetric HCP ☐ Prescribing or Other HCP, Specify: ____
☐ Other, HCP - Specify Specialty: ____

2. PREGNANCY INFORMATION2.1.1 Last Menstrual Period (LMP): month ____ day ____ year ____ ☐ Unknown2.1.2 Expected Delivery Date (by LMP): month ____ day ____ year ____ ☐ Unknown

2.1.2.1 Expected Delivery Date (by IVF): month ____ day ____ year ____

2.1.3 Corrected Estimated Date of Delivery (CEDD) (by ultrasound):
month ____ day ____ year ____ ☐ Unknown

2.1.4 Current Gestational Week: ____

By: ☐ CEDD (by ultrasound) ☐ Expected Delivery Date ☐ LMP

2.2 Pregnancy Type:

- ☐ Singleton ☐ Twin ☐ Triplet ☐ Other, Specify #: ____

2.3 Is the patient experiencing any Pregnancy Complications? (Complete Adverse Events Form)

- | | |
|---|---|
| <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> Preterm labor |
| <input type="checkbox"/> Molar Pregnancy | <input type="checkbox"/> Intrauterine Growth Restriction (IUGR) |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Fetus large for Gestational Age |
| <input type="checkbox"/> Placental Abruption | <input type="checkbox"/> Maternal Obesity |
| <input type="checkbox"/> Pre-eclampsia/pregnancy induced hypertension/proteinuria | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Eclampsia | <input type="checkbox"/> Other, Specify: ____ |
| <input type="checkbox"/> Premature Rupture of Membranes (PROM) | <input type="checkbox"/> None |
| | <input type="checkbox"/> Unknown |

2.4 Is the Patient Experiencing Any Acute Medical Conditions Not Related to The Pregnancy Or Pregnancy Complications? (e.g. infection, etc.) (Complete Adverse Events Form)

- ☐ Yes, specify: ____ ☐ No ☐ Unknown



3. MATERNAL DEMOGRAPHICS

3.1 Patient's Date of Birth: month _____ day _____ year _____

3.2 Patient's Race:

- ☐ American Indian or Alaska Native
☐ Black or African American
☐ Multiracial
☐ Native Hawaiian or Other Pacific Islander

- ☐ Asian
☐ Caucasian
☐ Declined to Answer
☐ Other, specify: _____

3.3 Patient's Ethnicity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Not Provided

3.4 Patient Height ☐ Unknown

☐ Feet/Inches ☐ Meters/Centimeters
_____ Feet _____ Inches _____ Meters _____ Centimeters

3.5 Patient Pre-Pregnancy Weight ☐ Unknown

Pre-pregnancy weight: _____ ☐ pounds ☐ kilograms

Pre-Pregnancy BMI: _____

3.6 Patient Current Weight ☐ Unknown

Current weight: _____ ☐ pounds ☐ kilograms

3.7 Patient's Highest Level of Education:

- | | |
|---|---|
| <input type="checkbox"/> No High School | <input type="checkbox"/> Associate's Degree (2-year degree) |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Advanced Degree |
| <input type="checkbox"/> Some College | <input type="checkbox"/> Unknown |

3.8 Does the patient currently use tobacco?

☐ Yes, packs per day: _____ ☐ No ☐ Unknown

Does the patient currently drink alcohol?

☐ Yes ☐ No ☐ Unknown

Does the patient use illicit drugs?

☐ Yes, name(s) of illicit drugs? _____ ☐ No ☐ Unknown

3.9 Has the Patient Had Any Exposures Affecting The Pregnancy Or Pregnancy Outcome?

☐ Yes ☐ No ☐ Unknown

Teratogenic Exposures

- ☐ Occupational, specify: _____
☐ Environmental, specify: _____

☐ Other, specify: _____

3.10 Are there Any Paternal Exposures Potentially Affecting The Pregnancy Or Pregnancy Outcome?

☐ Yes ☐ No ☐ Unknown

☐ Drugs, specify: _____

☐ Occupational, specify: _____

☐ Environmental, specify: _____

☐ Other, specify: _____

4. OBSTETRICAL HISTORY

4.1 Gravida: _____ Para: _____

of previous pregnancy outcomes (exclude current pregnancy) (account for multiple gestation pregnancies): _____

of previous spontaneous abortions (< 20 weeks gestation): _____

of previous (elective or therapeutic) abortions: _____

of previous stillbirths (\geq 20 weeks gestation): _____

of previous pregnancy outcomes with birth defects: _____

5. PERSONAL OR FAMILIAL HISTORY OF BIRTH DEFECTS

5.1 Maternal (Pregnant Patient)

Is there a family history of birth defects/abnormalities/or hereditary/genetic disorders for the pregnant patient (mother, father, or other offspring)?

☐ Yes ☐ None ☐ Unknown

Birth Defect(s): _____

Relationship to Pregnant Patient: _____

Paternal (Father of Baby)

Is there a family history of birth defects/abnormalities/or hereditary/genetic disorders for the father of the baby (mother, father, or other offspring)?

☐ Yes ☐ None ☐ Unknown

Birth Defect(s): _____

Relationship to Father of Baby: _____

6. PRENATAL IMAGING AND ANEUPLOIDY SCREENING/TESTING

6.1 Have any prenatal tests been performed?

☐ Yes ☐ No ☐ Unknown

Prenatal Test Type

☐ Ultrasound

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Amniocentesis

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Maternal Serum Screening

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ AFP

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Chorionic Villus Sampling

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Fetal Stress Test

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Serology Test

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____



☐ Genetic Screening

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Other Test Type, specify: _____

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____

☐ Other Test Type, specify: _____

Prenatal Test Date: month _____ day _____ year _____ Unknown: ☐

Gestational Age at time of testing/diagnosis (weeks): _____ Unknown: ☐

Indication for Test: ☐ Screening ☐ Other, specify: _____ ☐ Unknown

Was evidence of a structural or chromosomal defect noted:

☐ Yes ☐ No ☐ Unknown

(If Yes, please complete Adverse Events Form)

If a structural/chromosomal defect was noted, please specify: _____



7. PAST AND CURRENT MIGRAINE MEDICATION EXPOSURE

Please document all past and current migraine medications:

☐ Fremanezumab/AJOVY®

AJOVY Batch Number: _____ Unknown ☐

Indication: ☐ Acute ☐ Preventive

AJOVY Expiration Date: month _____ day _____ year _____ Unknown ☐

Ajovy Dose and Unit: ☐ 225 mg ☐ 675 mg ☐ Unknown

Ajovy Frequency: ☐ 1x1 month ☐ 1x3 months

☐ Other, specify: _____ ☐ Unknown

Ajovy Device: ☐ N/A ☐ Auto-injector ☐ Prefilled syringe ☐ Unknown

Action Taken with the Drug:

☐ 1=Drug Discontinued

☐ 4= Dose Reduced

☐ 2=No Change

☐ 5= Unknown

☐ 3= Dose Increased

☐ 6=Not Applicable

Start Date: month _____ day _____ year _____ Unknown ☐

Trimester of Exposure:

☐ 0=Prior to Pregnancy

☐ 1=First (0 to <14 weeks)

☐ 2=Second (14-27 weeks)

☐ 3=Third (28 - <41 weeks)

☐ Unknown

Stop Date: month _____ day _____ year _____

☐ Ongoing ☐ Unknown

☐ Other Medication, specify: _____

Indication: ☐ Acute ☐ Preventive

Dose: _____

Unit:

☐ mg

☐ top

☐ Application

☐ g

☐ Tbsp.

☐ Suppository

☐ mL

☐ Tablet

☐ Unknown

☐ mEq

☐ Patch

☐ Other, specify:

☐ gtt

☐ Puff

☐ IU

☐ Lozenge

☐ ug



Frequency:

- | | | |
|--|---|--|
| <input type="checkbox"/> QD | <input type="checkbox"/> Q 4H | <input type="checkbox"/> PRN |
| <input type="checkbox"/> BID | <input type="checkbox"/> Q 6H | <input type="checkbox"/> Once |
| <input type="checkbox"/> TID | <input type="checkbox"/> Q 8H | <input type="checkbox"/> Every 2 weeks |
| <input type="checkbox"/> QID | <input type="checkbox"/> Q 12H | <input type="checkbox"/> Every 8 weeks |
| <input type="checkbox"/> QOD | <input type="checkbox"/> 2 times per week | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> 5 times per day | <input type="checkbox"/> 3 times per week | |
| <input type="checkbox"/> 1 time per week | <input type="checkbox"/> QM | |
| <input type="checkbox"/> Other, Frequency Specify: _____ | | |

Route:

- | | |
|--|---|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Respiratory (inhalation) |
| <input type="checkbox"/> Intravenous | <input type="checkbox"/> Intra-Articular |
| <input type="checkbox"/> Intramuscular | <input type="checkbox"/> Intraocular |
| <input type="checkbox"/> Oral | <input type="checkbox"/> Intralesional |
| <input type="checkbox"/> Subcutaneous | <input type="checkbox"/> Intradermal |
| <input type="checkbox"/> Rectal | <input type="checkbox"/> Vaginal |
| <input type="checkbox"/> Sublingual | <input type="checkbox"/> Intrauterine |
| <input type="checkbox"/> Ophthalmic | <input type="checkbox"/> Nasal |
| <input type="checkbox"/> Topical | <input type="checkbox"/> Intrapleural |
| <input type="checkbox"/> Transdermal | <input type="checkbox"/> Auricular (Otic) |
| <input type="checkbox"/> Transmucosal | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Epidural | |

Action Taken with the Drug:

- | | |
|--|---|
| <input type="checkbox"/> 1=Drug Discontinued | <input type="checkbox"/> 4= Dose Reduced |
| <input type="checkbox"/> 2=No Change | <input type="checkbox"/> 5= Unknown |
| <input type="checkbox"/> 3= Dose Increased | <input type="checkbox"/> 6=Not Applicable |

Start Date: month _____ day _____ year _____ Unknown ☐

Trimester of Exposure:

- ☐ 0=Prior to Pregnancy
☐ 1=First (0 to <14 weeks)
☐ 2=Second (14-27 weeks)
☐ 3=Third (28 - <41 weeks)
☐ Unknown

Stop Date: month _____ day _____ year _____
☐ Ongoing ☐ Unknown



8. MEDICAL HISTORY (including prior and current medical history)

(Diabetes, High Blood Pressure/hypertension, Cardiovascular Disease, Epilepsy or other seizure disorder, Depression, Anxiety, Hepatitis, Thyroid Disease, Autoimmune Disease (e.g. Lupus, Multiple Sclerosis), High Cholesterol, Polycystic Ovary Syndrome, COVID-19)(If start date is after ICF signature date, complete Adverse Events Form).

☐ None

Medical History: _____

Start Date: month _____ day _____ year _____ Unknown ☐

Stop Date: month _____ day _____ year _____ Ongoing ☐ Unknown ☐

Medical History: _____

Start Date: month _____ day _____ year _____ Unknown ☐

Stop Date: month _____ day _____ year _____ Ongoing ☐ Unknown ☐

Medical History: _____

Start Date: month _____ day _____ year _____ Unknown ☐

Stop Date: month _____ day _____ year _____ Ongoing ☐ Unknown ☐

Medical History: _____

Start Date: month _____ day _____ year _____ Unknown ☐

Stop Date: month _____ day _____ year _____ Ongoing ☐ Unknown ☐

9. PRIOR AND CONCOMITANT MEDICATIONS FOR OTHER CONDITIONS (OTHER THAN PREVENTIVE MIGRAINE)(If Date Exposure Started is after ICF signature date, complete AE Form)(e.g., prescription, acute or oral migraine, non-prescription, herbal supplements, vaccinations, over-the-counter medications, multi-vitamin, folic acid, etc.)

Is the patient currently taking any medications and/or taken any medications within 6 months prior to Registry enrollment? ☐ Yes ☐ No

Medication: _____ **Batch Number:** _____ **Unknown** ☐ **Indication:** _____

Dose: _____

Unit:

☐ mg

☐ g

☐ mL

☐ mEq

☐ gtt

☐ IU

☐ Other, Dose Unit Specify: _____

☐ ug

☐ top

☐ Tbsp.

☐ Tablet

☐ Patch

☐ Puff

☐ Lozenge

☐ Application

☐ Suppository

☐ Unknown

Frequency:

☐ QD

☐ BID

☐ TID

☐ QID

☐ QOD

☐ 5 times per day

☐ 1 time per week

☐ Other, Frequency Specify: _____

☐ Q 4H

☐ Q 6H

☐ Q 8H

☐ Q 12H

☐ 2 times per week

☐ 3 times per week

☐ QM

☐ PRN

☐ Once

☐ Every 2 weeks

☐ Every 8 weeks

☐ Unknown

Route/Device:

☐ Unknown

☐ Intravenous

☐ Intramuscular

☐ Oral

☐ Subcutaneous

☐ Rectal

☐ Sublingual

☐ Ophthalmic

☐ Other, Specify: _____

☐ Topical

☐ Transdermal

☐ Transmucosal

☐ Epidural

☐ Respiratory (inhalation)

☐ Intra-Articular

☐ Intraocular

☐ Intralesional

☐ Intradermal

☐ Vaginal

☐ Intrauterine

☐ Nasal

☐ Intrapleural

☐ Auricular (Otic)

☐ Auto-injector

☐ Prefilled syringe

Date Exposure Started: month _____ day _____ year _____ **Unknown** ☐

Date Exposure Stopped: month _____ day _____ year _____ **Ongoing** ☐ **Unknown** ☐



Medication: _____ **Batch Number:** _____ **Unknown** ☐ **Indication:** _____

Dose: _____

Unit:

- ☐ mg
- ☐ g
- ☐ mL
- ☐ mEq
- ☐ gtt
- ☐ IU
- ☐ Other, Dose Unit Specify: _____

- ☐ ug
- ☐ top
- ☐ Tbsp.
- ☐ Tablet
- ☐ Patch
- ☐ Puff

- ☐ Lozenge
- ☐ Application
- ☐ Suppository
- ☐ Unknown

Frequency:

- ☐ QD
- ☐ BID
- ☐ TID
- ☐ QID
- ☐ QOD
- ☐ 5 times per day
- ☐ 1 time per week
- ☐ Other, Frequency Specify: _____

- ☐ Q 4H
- ☐ Q 6H
- ☐ Q 8H
- ☐ Q 12H
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ QM

- ☐ PRN
- ☐ Once
- ☐ Every 2 weeks
- ☐ Every 8 weeks
- ☐ Unknown

Route/Device:

- ☐ Unknown
- ☐ Intravenous
- ☐ Intramuscular
- ☐ Oral
- ☐ Subcutaneous
- ☐ Rectal
- ☐ Sublingual
- ☐ Ophthalmic
- ☐ Other, Specify: _____

- ☐ Topical
- ☐ Transdermal
- ☐ Transmucosal
- ☐ Epidural
- ☐ Respiratory (inhalation)
- ☐ Intra-Articular
- ☐ Intraocular
- ☐ Intralesional

- ☐ Intradermal
- ☐ Vaginal
- ☐ Intrauterine
- ☐ Nasal
- ☐ Intrapleural
- ☐ Auricular (Otic)
- ☐ Auto-injector
- ☐ Prefilled syringe

Date Exposure Started: month _____ day _____ year _____ **Unknown** ☐

Date Exposure Stopped: month _____ day _____ year _____ **Ongoing** ☐ **Unknown** ☐



Medication: _____ **Batch Number:** _____ **Unknown** ☐ **Indication:** _____

Dose: _____

Unit:

- ☐ mg
- ☐ g
- ☐ mL
- ☐ mEq
- ☐ gtt
- ☐ IU
- ☐ Other, Dose Unit Specify: _____

- ☐ ug
- ☐ top
- ☐ Tbsp.
- ☐ Tablet
- ☐ Patch
- ☐ Puff

- ☐ Lozenge
- ☐ Application
- ☐ Suppository
- ☐ Unknown

Frequency:

- ☐ QD
- ☐ BID
- ☐ TID
- ☐ QID
- ☐ QOD
- ☐ 5 times per day
- ☐ 1 time per week
- ☐ Other, Frequency Specify: _____

- ☐ Q 4H
- ☐ Q 6H
- ☐ Q 8H
- ☐ Q 12H
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ QM

- ☐ PRN
- ☐ Once
- ☐ Every 2 weeks
- ☐ Every 8 weeks
- ☐ Unknown

Route/Device:

- ☐ Unknown
- ☐ Intravenous
- ☐ Intramuscular
- ☐ Oral
- ☐ Subcutaneous
- ☐ Rectal
- ☐ Sublingual
- ☐ Ophthalmic
- ☐ Other, Specify: _____

- ☐ Topical
- ☐ Transdermal
- ☐ Transmucosal
- ☐ Epidural
- ☐ Respiratory (inhalation)
- ☐ Intra-Articular
- ☐ Intraocular
- ☐ Intralesional

- ☐ Intradermal
- ☐ Vaginal
- ☐ Intrauterine
- ☐ Nasal
- ☐ Intrapleural
- ☐ Auricular (Otic)
- ☐ Auto-injector
- ☐ Prefilled syringe

Date Exposure Started: month _____ day _____ year _____ **Unknown** ☐

Date Exposure Stopped: month _____ day _____ year _____ **Ongoing** ☐ **Unknown** ☐



Medication: _____ **Batch Number:** _____ **Unknown** ☐ **Indication:** _____

Dose: _____

Unit:

- ☐ mg
- ☐ g
- ☐ mL
- ☐ mEq
- ☐ gtt
- ☐ IU
- ☐ Other, Dose Unit Specify: _____

- ☐ ug
- ☐ top
- ☐ Tbsp.
- ☐ Tablet
- ☐ Patch
- ☐ Puff

- ☐ Lozenge
- ☐ Application
- ☐ Suppository
- ☐ Unknown

Frequency:

- ☐ QD
- ☐ BID
- ☐ TID
- ☐ QID
- ☐ QOD
- ☐ 5 times per day
- ☐ 1 time per week
- ☐ Other, Frequency Specify: _____

- ☐ Q 4H
- ☐ Q 6H
- ☐ Q 8H
- ☐ Q 12H
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ QM

- ☐ PRN
- ☐ Once
- ☐ Every 2 weeks
- ☐ Every 8 weeks
- ☐ Unknown

Route/Device:

- ☐ Unknown
- ☐ Intravenous
- ☐ Intramuscular
- ☐ Oral
- ☐ Subcutaneous
- ☐ Rectal
- ☐ Sublingual
- ☐ Ophthalmic
- ☐ Other, Specify: _____

- ☐ Topical
- ☐ Transdermal
- ☐ Transmucosal
- ☐ Epidural
- ☐ Respiratory (inhalation)
- ☐ Intra-Articular
- ☐ Intraocular
- ☐ Intralesional

- ☐ Intradermal
- ☐ Vaginal
- ☐ Intrauterine
- ☐ Nasal
- ☐ Intrapleural
- ☐ Auricular (Otic)
- ☐ Auto-injector
- ☐ Prefilled syringe

Date Exposure Started: month _____ day _____ year _____ **Unknown** ☐

Date Exposure Stopped: month _____ day _____ year _____ **Ongoing** ☐ **Unknown** ☐



Medication: _____ **Batch Number:** _____ **Unknown** ☐ **Indication:** _____

Dose: _____

Unit:

- ☐ mg
- ☐ g
- ☐ mL
- ☐ mEq
- ☐ gtt
- ☐ IU
- ☐ Other, Dose Unit Specify: _____

- ☐ ug
- ☐ top
- ☐ Tbsp.
- ☐ Tablet
- ☐ Patch
- ☐ Puff

- ☐ Lozenge
- ☐ Application
- ☐ Suppository
- ☐ Unknown

Frequency:

- ☐ QD
- ☐ BID
- ☐ TID
- ☐ QID
- ☐ QOD
- ☐ 5 times per day
- ☐ 1 time per week
- ☐ Other, Frequency Specify: _____

- ☐ Q 4H
- ☐ Q 6H
- ☐ Q 8H
- ☐ Q 12H
- ☐ 2 times per week
- ☐ 3 times per week
- ☐ QM

- ☐ PRN
- ☐ Once
- ☐ Every 2 weeks
- ☐ Every 8 weeks
- ☐ Unknown

Route/Device:

- ☐ Unknown
- ☐ Intravenous
- ☐ Intramuscular
- ☐ Oral
- ☐ Subcutaneous
- ☐ Rectal
- ☐ Sublingual
- ☐ Ophthalmic
- ☐ Other, Specify: _____

- ☐ Topical
- ☐ Transdermal
- ☐ Transmucosal
- ☐ Epidural
- ☐ Respiratory (inhalation)
- ☐ Intra-Articular
- ☐ Intraocular
- ☐ Intralesional

- ☐ Intradermal
- ☐ Vaginal
- ☐ Intrauterine
- ☐ Nasal
- ☐ Intrapleural
- ☐ Auricular (Otic)
- ☐ Auto-injector
- ☐ Prefilled syringe

Date Exposure Started: month _____ day _____ year _____ **Unknown** ☐

Date Exposure Stopped: month _____ day _____ year _____ **Ongoing** ☐ **Unknown** ☐