Site Number	Screening Number	Participant Study Number	Protocol Number: MoCk - Up-1-001-06
VISIT 1 (SCREENING)			**SCREENING CONCOMITANT MEDICATIONS**

Has the participant taken any concomitant medications at screening or <insert time frame as specified in protocol> prior to screening?		☐ **No** ☐ **Yes,** Complete below		
Medication (Record <specify Generic or Brand> name)	**Reason for use** (Enter Medical History diagnosis or other reason for use, e.g. Prophylaxis)	**Start Date** (DD/MMM/YYYY)	**Stop Date** (DD/MMM/YYYY)	**Or tick if ongoing at Screening Visit**
1.		____/_____/_____	____/_____/_____	☐
2.		____/_____/_____	____/_____/_____	☐
3.		____/_____/_____	____/_____/_____	☐
4.		____/_____/_____	____/_____/_____	☐
5.		____/_____/_____	____/_____/_____	☐
6.		____/_____/_____	____/_____/_____	☐
7.		____/_____/_____	____/_____/_____	☐
8.		____/_____/_____	____/_____/_____	☐
9.		____/_____/_____	____/_____/_____	☐
10.		____/_____/_____	____/_____/_____	☐