MEDICATION DIARY / NOTEBOOK

- research-

HD-MED: Pharmacogenetics in Huntington's Disease

Name: ……..………………………………………………

Start date HD-MED study: …………………………………………………..

Notes / questions to be asked to the researcher:

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In front of you is the medication diary. This is meant to help you keep track of changes in your medication usage. In this diary, you can note dosage adjustments, start and stop dates of medications, and short courses of treatment prescribed by your doctor. Each different side effect of a medication can be written on a new line. Please use a new table for each medication.

We kindly request you to **keep track of all medications and supplements** in the diary. This includes hormones (like 'the pill'), inhalers, ointments prescribed by the dermatologist, and eye drops prescribed by the eye doctor. Medications that you don't use daily but less frequently (for example, every other week or only during a specific season) should also be recorded in this diary. Additionally, please keep track of any substances (such as pain relievers or supplements like vitamins) that you use daily or almost daily from the pharmacy.

Every time you have contact with the researcher, they will ask you about the diary. If you run out of tables, you can call or email the contact information provided below, and we will send you more tables. Please remember to bring your diary with you when you visit the neurology department for a check-up.

Example: You can write down the dosage of the medications like this: 1x per day 2.5mg, 3x per day 1 puff, etc. You will also find this information on the label on the medication box.
Tip: Place this diary in a spot where you won't forget it (for example, in the medicine cabinet).

Once again, thank you very much for participating in this research!

Also on behalf of S.T. de Bot, neurologist

S. Feleus, MD and study coordinator
[contact details email, telephone and postal address]

Medication/Supplement name:	Dosage:	Start date:
		[day] [month] [year]

Symptoms for which you use this medication:	Effect op symptoms: 0=no effect, 5=perfect effect
	0 – 1 – 2 – 3 – 4 – 5

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Stopped on date: [day] [month] [year]	Reason for stopping: ☐ I switched to another medication/supplement for the same symptoms. The new medication is called . . . . ☐ Other reason, namely. . . . .

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