

# CRF Report for Study E7694105S

Report run by Tressa Brown at 11-FEB-2013 10:52:27

## Report Parameters

Site: CDB\_001

Discrepancy status choice: All statuses

Approval status choice: All statuses

Verification status choice: All statuses

Starting patient: R1018

Ending patient: R1018

## Legend: How different values appear in the report

Prompt	Abc 123
Data value	Abc 123
Data value with discrepancy	<b>Abc 123</b>

All time stamps displayed in this report are in the timezone of the database server.

The data contained in this report is current at the time of printing (time as shown above)



Initials:

(b)

Subject #:

R1018

Is Blank

MINNESOTA NICOTINE WITHDRAWAL SCALE

Minnesota Nicotine Withdrawal Scale (check answers)

Time Taken:  (24-hr clock)

Please rate yourself for the period of the last 24 hours.  
0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

- |   |                                     |                          |                                     |                          |                                     |                          |                                     |
|---|-------------------------------------|--------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|-------------------------------------|
| 1. Angry, irritable, frustrated                 | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 2. Anxious, nervous                             | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 3. Depressed mood, sad                          | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 4. Desire or craving to smoke                   | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Difficulty concentrating                     | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 6. Increased appetite, hungry, weight gain      | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 7. Insomnia, sleep problems, awakening at night | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 8. Restless                                     | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| 9. Impatient                                    | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |

Date:

Total Score:

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R1018

Is Blank

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

Fagerstrom Test for Nicotine Dependence (check answers)

Time Taken:  (24-hr clock)

1. How soon after waking do you smoke your first cigarette?

- Less than five minutes
- 5-30 minutes
- 31-60 minutes
- More than an hour

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- Yes
- No

3. Which cigarette would you hate to give up?

- First one in the morning?
- Any other

4. How many cigarettes do you smoke per day?

- More than 30 per day
- 21-30 per day
- 11-20 per day
- 10 or less per day

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?

- Yes
- No

6. Do you smoke if you are so ill that you are in bed most of the day?

- Yes
- No

Date:

Total Score:

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Subject #:

R1018

WEEK 6

Is Blank

MINNESOTA NICOTINE WITHDRAWAL SCALE

Minnesota Nicotine Withdrawal Scale (check answers)

Time Taken:  (24-hr clock)

Please rate yourself for the period of the last 24 hours.  
0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

- |   |                                     |                          |                                     |                                     |                          |                          |                          |                                     |                          |
|---|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|
| 1. Angry, irritable, frustrated                 | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 2. Anxious, nervous                             | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 3. Depressed mood, sad                          | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 4. Desire or craving to smoke                   | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Difficulty concentrating                     | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 6. Increased appetite, hungry, weight gain      | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 7. Insomnia, sleep problems, awakening at night | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 8. Restless                                     | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 9. Impatient                                    | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |

Date:

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WEEK 10

Is Blank

MINNESOTA NICOTINE WITHDRAWAL SCALE

Minnesota Nicotine Withdrawal Scale (check answers)

Time Taken:  (24-hr clock)

Please rate yourself for the period of the last 24 hours.  
0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

- |   |                          |   |                          |   |                          |   |                          |   |                          |   |
|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|
| 1. Angry, irritable, frustrated                 | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 2. Anxious, nervous                             | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 3. Depressed mood, sad                          | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 4. Desire or craving to smoke                   | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 5. Difficulty concentrating                     | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 6. Increased appetite, hungry, weight gain      | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 7. Insomnia, sleep problems, awakening at night | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 8. Restless                                     | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 9. Impatient                                    | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |

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Initials:

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Subject #:

R1018

WEEK 16

Is Blank

MINNESOTA NICOTINE WITHDRAWAL SCALE

Minnesota Nicotine Withdrawal Scale (check answers)

Time Taken:  (24-hr clock)

Please rate yourself for the period of the last 24 hours.  
0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

- |   |                                       |                                       |                                       |                                       |                            |
|---|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|----------------------------|
| 1. Angry, irritable, frustrated                 | <input type="checkbox"/> 0            | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2            | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 2. Anxious, nervous                             | <input type="checkbox"/> 0            | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 2            | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 3. Depressed mood, sad                          | <input checked="" type="checkbox"/> 0 | <input type="checkbox"/> 1            | <input type="checkbox"/> 2            | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 4. Desire or craving to smoke                   | <input type="checkbox"/> 0            | <input type="checkbox"/> 1            | <input checked="" type="checkbox"/> 2 | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 5. Difficulty concentrating                     | <input checked="" type="checkbox"/> 0 | <input type="checkbox"/> 1            | <input type="checkbox"/> 2            | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 6. Increased appetite, hungry, weight gain      | <input type="checkbox"/> 0            | <input type="checkbox"/> 1            | <input type="checkbox"/> 2            | <input checked="" type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| 7. Insomnia, sleep problems, awakening at night | <input checked="" type="checkbox"/> 0 | <input type="checkbox"/> 1            | <input type="checkbox"/> 2            | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 8. Restless                                     | <input type="checkbox"/> 0            | <input type="checkbox"/> 1            | <input checked="" type="checkbox"/> 2 | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |
| 9. Impatient                                    | <input type="checkbox"/> 0            | <input type="checkbox"/> 1            | <input checked="" type="checkbox"/> 2 | <input type="checkbox"/> 3            | <input type="checkbox"/> 4 |

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WEEK 16

Is Blank

Did subject smoke at least 1 cigarette per day during the past week?  Yes  No

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Initials:

(b)

Subject #:

R1018

WEEK 16

Is Blank

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

Fagerstrom Test for Nicotine Dependence (check answers)

Time Taken:  (24-hr clock)

1. How soon after waking do you smoke your first cigarette?

- Less than five minutes
- 5-30 minutes
- 31-60 minutes
- More than an hour

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- Yes
- No

3. Which cigarette would you hate to give up?

- First one in the morning?
- Any other

4. How many cigarettes do you smoke per day?

- More than 30 per day
- 21-30 per day
- 11-20 per day
- 10 or less per day

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?

- Yes
- No

6. Do you smoke if you are so ill that you are in bed most of the day?

- Yes
- No

Date:

Total Score:

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Page Version No. FAGERSTROM (v1, 25-MAR-2009)

Document Number

Initials:

(b)

Subject #:

R1018

WEEK 28

Is Blank

MINNESOTA NICOTINE WITHDRAWAL SCALE

Minnesota Nicotine Withdrawal Scale (check answers)

Time Taken:  (24-hr clock)

Please rate yourself for the period of the last 24 hours.  
0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

- |   |                          |   |                          |   |                          |   |                          |   |                          |   |
|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|
| 1. Angry, irritable, frustrated                 | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 2. Anxious, nervous                             | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 3. Depressed mood, sad                          | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 4. Desire or craving to smoke                   | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 5. Difficulty concentrating                     | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 6. Increased appetite, hungry, weight gain      | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 7. Insomnia, sleep problems, awakening at night | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 8. Restless                                     | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |
| 9. Impatient                                    | <input type="checkbox"/> | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 |

Date:

Total Score:

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Initials:

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R1018

WEEK 28

Is Blank

Did subject smoke at least 1 cigarette per day during the past week?  Yes  No

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Document Number R289383313

Initials:

(b)

Subject #:

R1018

WEEK 28

Is Blank

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

Fagerstrom Test for Nicotine Dependence (check answers)

Time Taken:  (24-hr clock)

1. How soon after waking do you smoke your first cigarette?

- Less than five minutes
- 5-30 minutes
- 31-60 minutes
- More than an hour

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- Yes
- No

3. Which cigarette would you hate to give up?

- First one in the morning?
- Any other

4. How many cigarettes do you smoke per day?

- More than 30 per day
- 21-30 per day
- 11-20 per day
- 10 or less per day

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?

- Yes
- No

6. Do you smoke if you are so ill that you are in bed most of the day?

- Yes
- No

Date:

Total Score:

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Document Number R273079313

## Appendix: Audit and Discrepancy Information



# Audit History Report

This section lists audited data that meets the parameters set when the report was run. It may not include all of the audited data in a particular CRF. Refer to the documentation for a complete description of the parameters that can affect this report.



# Discrepancy Detail Report

# Deleted CRFs Report