Subject Initials: _____ Subject Number: _____ Date: _____

MEDICAL HISTORY FORM

Date Of Birth: _____ Sex: _____ SSN: _____

Note: We are required to collect SSNs from all subjects. In the event that >$600 is received for study participation in a calendar year, we are required to send a 1099 form for tax reporting purposes.

Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____ Emergency Contact number: _____

Mailing Address: _____

Height:_____ Weight:_____ Race:_____ Ethnicity:_____

Have You Ever Participated In A Study /When:_____

CURRENT MEDICAL ILLNESS: _____

CURRENTLY UNDER CARE OF:_____

REVIEW OF BODY SYSTEMS/MEDICAL HISTORY

CARDIOVASCULAR

Diagnosis	Date Of Diagnosis	Currently TX
( ) Angina	_____	_____
( ) Coronary Artery Disease	_____	_____
( ) Congestive Heart Failure	_____	_____
( ) Chest Pain	_____	_____
( ) Myocardial Infarction	_____	_____
( ) Peripheral Vascular Disease	_____	_____
( ) Hypertension	_____	_____
( ) Elevated Cholesterol/ Lipids	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

GENITOURINARY

Diagnosis	Date Of Diagnosis	Currently TX
( ) Incontinence	_____	_____
( ) Urinary Tract Infection	_____	_____
( ) Kidney Stones	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

Subject Initials: _____ Subject Number: _____ Date: _____

RESPIRATORY

Diagnosis	Date Of Diagnosis	Currently TX
( ) Asthma	_____	_____
( ) Bronchitis	_____	_____
( ) COPD	_____	_____
( ) Emphysema	_____	_____
( ) Pneumonia	_____	_____
( ) Tuberculosis	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) Smoker	yr started_____ quit date_____	_____
_____current _____former	_____#years smoked _____cigs per day=	_____pack years
( ) none for this system	_____initials	

NEUROLOGICAL

Diagnosis	Date Of Diagnosis	Currently TX
( ) Alzheimeimer's	_____	_____
( ) CVA	_____	_____
( ) TIA'S	_____	_____
( ) Migraine Headache	_____	_____
( ) Epilepsy	_____	_____
( ) Seizures	_____	_____
( ) Neuropathy	_____	_____
( ) Syncope	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

BEHAVIORAL

Diagnosis	Date Of Diagnosis	Currently TX
( ) Attention Deficit Disorder	_____	_____
( ) Anxiety	_____	_____
( ) Depression	_____	_____
( ) Substance Abuse	_____	_____
( ) Obsessive Compulsive Disorder	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

Subject Initials: _____ Subject Number: _____ Date: _____

MUSCULOSKELETAL

Diagnosis	Date Of Diagnosis	Currently TX
( ) Arthritis	_____	_____
( ) Rheumatoid Arthritis	_____	_____
( ) Osteoarthritis	_____	_____
( ) Osteoporosis	_____	_____
( ) Pain	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

GASTROINTESTINAL

Diagnosis	Date Of Diagnosis	Currently TX
( ) Cirrhosis of the Liver	_____	_____
( ) Gall Bladder Disease	_____	_____
( ) Pancreatitis	_____	_____
( ) Anorexia	_____	_____
( ) Bulimia	_____	_____
( ) Crohn's Disease	_____	_____
( ) Hepatitis	_____	_____
( ) Stomach Ulcer	_____	_____
( ) GERD/esophageal reflux	_____	_____
( ) Heart Burn	_____	_____
( ) Indigestion	_____	_____
( ) Constipation	_____	_____
( ) Diarrhea	_____	_____
( ) Irritable Bowel Disease	_____	_____
( ) Diverticulitis	_____	_____
( ) Prior Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

ENDOCRINOLOGY

Diagnosis	Date Of Diagnosis	Currently TX
( ) Diet-Controlled Diabetes I	_____	_____
( ) Insulin Dependent Diabetes II	_____	_____
( ) Oral Med. Diabetes II	_____	_____
( ) Hypothyroidism	_____	_____
( ) Hyperthyroidism	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

Subject Initials: _____ Subject Number: _____ Date: _____

EYES/EARS/NOSE/THROAT

Diagnosis	Date Of Diagnosis	Currently TX
( ) Retinopathy	_____	_____
( ) Glaucoma	_____	_____
( ) Cataracts	_____	_____
( ) Sinusitis	_____	_____
( ) Rhinitis	_____	_____
( ) Seasonal Allergies	_____	_____
( ) Perennial Allergies	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

REPRODUCTIVE

Diagnosis	Date Of Diagnosis	Currently TX
( ) Vasectomy	_____	_____
( ) Enlarged Prostate	_____	_____
( ) Sexual Dysfunction	_____	_____
( ) Hysterectomy	_____	_____
( ) Removal Of Ovaries	_____	_____
( ) Pre/Post Menopausal	_____	_____
( ) Endometriosis	_____	_____
( ) Sexually Trans Disease: _____	_____	_____
( ) Genital Herpes	_____	_____
( ) Genital Warts	_____	_____
( ) Yeast Infections	_____	_____
( ) Past Surgeries	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

DERMATOLOGICAL

Diagnosis	Date Of Diagnosis	Currently TX
( ) Psoriasis	_____	_____
( ) Allergic Contact Dermatitis	_____	_____
( ) Atopic Dermatitis	_____	_____
( ) Hair Loss	_____	_____
( ) Rash/Lesions	_____	_____
( ) Other: _____	_____	_____
( ) none for this system	_____initials	

Subject Initials: _____ Subject Number: _____ Date: _____

ONCOLOGY/HEMATOLOGY

List Any Diagnosis and/or Treatment:

_____

_____

_____

PAST MEDICAL PROCEDURES

_____

_____

_____

PAST HOSPITAL ADMISSIONS

_____

_____

_____

ANY FUTURE PLANNED ELECTIVE SURGERIES?

_____

_____

_____

MEDICATION PROFILE -Please List Any Medications not previously entered Include All Over The Counter Med. & Topicals_____

_____

_____

_____

_____

SIGNATURE OF SUBJECT/GUARDIAN: _____

SIGNATURE OF PERSON COMPLETING FORM:_____Date:_____

PHYSICIAN SIGNATURE/DATE OF REVIEW:_____Date:_____