

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

<u>Diagnosis</u>	<u>Date Of Diagnosis</u>	<u>Currently TX</u>
() 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

<u>Diagnosis</u>	<u>Date Of Diagnosis</u>	<u>Currently TX</u>
() Incontinence	_____	_____
() Urinary Tract Infection	_____	_____
() Kidney Stones	_____	_____
() Past Surgeries	_____	_____
() 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: _____

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: _____