Medical History

Name: _____ Initials: _____ DOB: _____
First Middle Last

Address: _____
Street City State Zip

Phone #1: _____ Phone #2: _____ Email: _____

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black/African American
☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
First Middle Last

Address: _____
Street City State Zip

Phone #1: _____ Phone #2: _____

CONDITIONS: Check YES or NO column as appropriate. Please specify dates as completely as possible.

Condition	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
GENERAL						
Fever of unknown cause				/ /	☐	/ /
Chills				/ /	☐	/ /
Weight loss/ weight gain				/ /	☐	/ /
Loss of appetite				/ /	☐	/ /
Other:				/ /	☐	/ /
SKIN CANCER						
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /
CANCER (All other)						
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /
EYES						
Eye Glasses			reading/near-sighted/far-sighted	/ /	☐	/ /
Glaucoma				/ /	☐	/ /
Dry Eyes				/ /	☐	/ /
Cataracts: ☐R ☐L ☐Bilateral				/ /	☐	/ /

Name_____ Date of Birth _____

Other:				/ /	☐	/ /
EARS						
Hearing Loss: ☐R ☐L ☐Bilateral				/ /	☐	/ /
Ringing/ Buzzing				/ /	☐	/ /
Chronic Ear Infections				/ /	☐	/ /
Other:				/ /	☐	/ /
NOSE OR THROAT						
Sinus Infections				/ /	☐	/ /
Nose Bleeds				/ /	☐	/ /
Chronic Nasal/Sinus congestion				/ /	☐	/ /
Tonsillitis				/ /	☐	/ /
Other:				/ /	☐	/ /
CARDIOVASCULAR	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
High Blood Pressure				/ /	☐	/ /
High Cholesterol				/ /	☐	/ /
Heart Murmur				/ /	☐	/ /
Heart Attack				/ /	☐	/ /
Peripheral Vascular Disease (PVD)				/ /	☐	/ /
Angina/ Chest Pain				/ /	☐	/ /
Congestive Heart Failure				/ /	☐	/ /
Arrhythmia/Irregular heart rate				/ /	☐	/ /
Dizziness or Fainting				/ /	☐	/ /
Abdominal Aortic Aneurysm				/ /	☐	/ /
Deep Vein Thrombosis/ Blood Clots				/ /	☐	/ /
Pulmonary Embolism				/ /	☐	/ /
Coronary Artery Disease:				/ /	☐	/ /
Heart Attack/MI			/ / , / / , / /			
Angioplasty			/ / , / / , / /			
Stent			/ / , / / , / /			
Coronary Artery Bypass			/ / , / / , / /			
Other:				/ /	☐	/ /
LUNG / RESPIRATORY						
Asthma				/ /	☐	/ /
Chronic Bronchitis				/ /	☐	/ /
Pneumonia				/ /	☐	/ /
Chronic Cough				/ /	☐	/ /
COPD/Emphysema				/ /	☐	/ /
Shortness of Breath				/ /	☐	/ /
Sleep Apnea				/ /	☐	/ /
Tuberculosis				/ /	☐	/ /
Other:				/ /	☐	/ /

Name_____ Date of Birth _____

ENDOCRINE						
Diabetes Type I				/ /	☐	/ /
Diabetes Type II				/ /	☐	/ /
Hyperthyroidism				/ /	☐	/ /
Hypothyroidism				/ /	☐	/ /
Goiter				/ /	☐	/ /
Obesity				/ /	☐	/ /
Other:				/ /	☐	/ /
GENITOURINARY						
Kidney Disease				/ /	☐	/ /
Urinary Tract Infections (chronic)				/ /	☐	/ /
Kidney Stones				/ /	☐	/ /
Incontinence/ Bladder Control Problems				/ /	☐	/ /
Sexually Transmitted Disease				/ /	☐	/ /
Low libido				/ /	☐	/ /
Difficulty w/ sexual arousal				/ /	☐	/ /
Other:				/ /	☐	/ /
GYNECOLOGICAL ☐ NA if Male	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Vaginal Infections				/ /	☐	/ /
Abnormal Pap Smear				/ /	☐	/ /
Abnormal Mammogram				/ /	☐	/ /
Fibrocystic Breast Disease (cysts)				/ /	☐	/ /
Hot Flashes				/ /	☐	/ /
Irregular Menstrual Cycle				/ /	☐	/ /
Postmenopausal			☐ natural or ☐ surgical	/ /	☐	
Other:				/ /	☐	/ /
MALE DISORDERS ☐ NA if Female						
Premature Ejaculation				/ /	☐	/ /
Enlarged Prostate (BPH)				/ /	☐	/ /
Impotence/Erectile Dysfunction				/ /	☐	/ /
Other:				/ /	☐	/ /
GASTROINTESTINAL						
Liver Disease				/ /	☐	/ /
Hepatitis				/ /	☐	/ /
Gall Bladder Disease				/ /	☐	/ /
Pancreatitis				/ /	☐	/ /
Heartburn				/ /	☐	/ /
Ulcer: (specify type)				/ /	☐	/ /
Recurrent Abdominal Pain				/ /	☐	/ /
Hernia: (specify type)				/ /	☐	/ /
Constipation				/ /	☐	/ /
Diarrhea				/ /	☐	/ /

Name_____ Date of Birth _____

Irritable Bowel Syndrome (IBS)				/ /	☐	/ /
Blood in Stool				/ /	☐	/ /
Hemorrhoids				/ /	☐	/ /
Diverticulosis				/ /	☐	/ /
Diverticulitis				/ /	☐	/ /
Ulcerative Colitis				/ /	☐	/ /
Crohn's Disease				/ /	☐	/ /
Celiac Disease/Gluten Intolerance				/ /	☐	/ /
Appendicitis				/ /	☐	/ /
Other:				/ /	☐	/ /
SKIN						
Acne (current)				/ /	☐	/ /
Rosacea				/ /	☐	/ /
Atopic Dermatitis / Eczema				/ /	☐	/ /
Cold Sores, Herpes Simplex				/ /	☐	/ /
Psoriasis				/ /	☐	/ /
Recurrent Rashes				/ /	☐	/ /
Bruising				/ /	☐	/ /
Other:				/ /	☐	/ /
MUSCULOSKELETAL	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Osteoarthritis				/ /	☐	/ /
Rheumatoid Arthritis				/ /	☐	/ /
Osteoporosis				/ /	☐	/ /
Osteopenia				/ /	☐	/ /
Fractures/Broken Bones (#1)				/ /	☐	/ /
Fractures/Broken Bones (#2)				/ /	☐	/ /
Fractures/Broken Bones (#3)				/ /	☐	/ /
Fractures/Broken Bones(#4)				/ /	☐	/ /
Leg Cramps				/ /	☐	/ /
Fibromyalgia				/ /	☐	/ /
Recurrent Joint Pain				/ /	☐	/ /
Recurrent Back Pain				/ /	☐	/ /
Recurrent Neck Pain				/ /	☐	/ /
Degenerative Disc Disease				/ /	☐	/ /
Gout				/ /	☐	/ /
Other:				/ /	☐	/ /
NEUROLOGICAL						
Seizure Disorder				/ /	☐	/ /
Insomnia				/ /	☐	/ /
Frequent Headaches				/ /	☐	/ /
Numbness/ Tingling (location)				/ /	☐	/ /

Name_____ Date of Birth _____

Multiple Sclerosis				/ /	☐	/ /
Paralysis				/ /	☐	/ /
Tremors				/ /	☐	/ /
Parkinson's Disease				/ /	☐	/ /
Stroke				/ /	☐	/ /
Transient Ischemic Attack (TIA) or "mini-stroke"				/ /	☐	/ /
Cerebral Hemorrhage				/ /	☐	/ /
Other:				/ /	☐	/ /
PSYCHOLOGICAL						
Drug or Alcohol Abuse				/ /	☐	/ /
Depression				/ /	☐	/ /
Anxiety/ Panic Attack(s)				/ /	☐	/ /
Eating Disorder				/ /	☐	/ /
Psychotic Episode(s)				/ /	☐	/ /
Bi-Polar Disorder				/ /	☐	/ /
Schizophrenia				/ /	☐	/ /
Dementia				/ /	☐	/ /
Alzheimer's				/ /	☐	/ /
Other:				/ /	☐	/ /
Other				/ /	☐	/ /
IMMUNE SYSTEM	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
HIV				/ /	☐	/ /
Immune Deficiency Disorder				/ /	☐	/ /
Lupus				/ /	☐	/ /
Chronic Fatigue				/ /	☐	/ /
Other:				/ /	☐	/ /
BLOOD DISORDER						
Anemia				/ /	☐	/ /
Clotting / Bleeding problems				/ /	☐	/ /
Low platelets				/ /	☐	/ /
Low White blood cell count				/ /	☐	/ /
Other**:**				/ /	☐	/ /

ALLERGIES: List all including medications environmental, food, & dyes:

Allergic to:	**Reaction (Must be listed in Med Hx)**	**Start Date**
Example: Cats	Itchy Eyes	/ /1960
Example: Penicillin	Airway swelling	/ /1972
		/ /
		/ /
		/ /
		/ /

Name____ Date of Birth ___________________________

MEDICATIONS: List all medications, over the counter supplements, vitamins or herbal remedies that you now take as well as any you have taken in the last *30 DAYS*.

Medication/Supplement	Dose	Rt. of Admin	Frequency	Indication	Start Date	Cont	Stop Date
Example: Osco Vitamin C	**500mg**	**Orally**	**X1 a day**	**General Health**	02/--/1990	**X**	
Example: Lipitor	**20mg**	**Orally**	**X1 a day**	**High Cholesterol**	06/--/2010	**X**	
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Name_____ Date of Birth _____

SURGERIES / HOSPITALIZATIONS: List all including childbirth

Description	Reason/Condition (Must be listed in Med Hx)	Date
Example: Appendectomy	Appendicitis	/ /1992
Example: Normal Vaginal Delivery	Childbirth	02 / 09 /1982
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FEMALES ONLY

Date of last natural menstrual period: ____/____/____
Are you currently pregnant? ☐Yes ☐No
Are you currently breastfeeding? ☐Yes ☐No

Are you able to have children? ☐ Yes ☐ No

If **Yes**, please complete below	If **No**, please complete below
Are you sexually active? (at least 1X in last year) ☐Yes ☐No (If yes, list BC methods below. If no, list the BC methods you would use if you become sexually active) Birth Control Method (#1):_____ Birth Control Method (#2):_____	☐ Post-Menopausal ☐ Hysterectomy (uterus removed), date____/____/____ ☐ Tubal Ligation (tubes tied), date ___/____/____ ☐ Ovaries removed, ☐R ☐L ☐Both ____/____/____ ☐ Other_____

MALES ONLY

Are you able to father children? ☐ Yes ☐ No

If **Yes**, please complete below	If **No**, please complete below
Are you sexually active? (at least 1X in last year) ☐Yes ☐No (If yes, list BC methods below. If no, list the BC methods you would use if you become sexually active) Birth Control Method (#1):_____ Birth Control Method (#2):_____	☐ Vasectomy, date____/____/____ ☐ Impotent/Erectile Dysfunction ☐ Other_____

Name____ Date of Birth ___________________________

SOCIAL HISTORY:

	Alcohol	Nicotine
Never Used	☐	☐
Ex-User	☐	☐
Currently Use	☐	☐
Start Date	/ /	Please provide details on type, start, and stop date(s):
Stop Date	/ /	
	_____ Drinks/Week 1 drink = -5oz wine -12 oz beer -1oz liquor	____ Packs/day ____/____/____ to ____/____/____ ____ cigars/day ____/____/____ to ____/____/____ ____ pipes/day ____/____/____ to ____/____/____ ____ pinches/day ____/____/____ to ____/____/____ ____ gum/day ____/____/____ to ____/____/____ ____ patches/day ____/____/____ to ____/____/____

	Caffeine		Recreational Drug Use
Never Used	☐		☐
Ex-User	☐		☐
Currently Use	☐		☐
Start Date	/ /		/ /
Stop Date	/ /		/ /
	Type	oz/day	Please provide details:
	Example: Diet Coke	12	

FAMILY HISTORY: (please indicate any family members with the following conditions)

Relative			Heart Disease	Cancer	Diabetes
Father		Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________
Mother		Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________
Circle one	Son Daughter Brother Sister	Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________
Circle one	Son Daughter Brother Sister	Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________
Circle one	Son Daughter Brother Sister	Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________
Circle one	Son Daughter Brother Sister	Age at onset:	☐ Yes ☐ No Age = _________	☐ Yes ☐ No If yes, type:___________ Age =___________	☐ Yes ☐ No Age =________

Name_____ Date of Birth _____

BLOOD DONATION

Have you donated blood within the past year? ☐ Yes ☐ No, If yes, most recent donation:____/____/____
Have you received blood or blood products within the last year? ☐ Yes ☐ No

Please explain_____

Have you participated in a study within the past 30 days that required long visits with multiple blood draws?

☐ Yes ☐ No; If yes, how many visits were there and what was the date time frame?

# of visits: _____ Dates: ____/____/____ through ____/____/____

Approximate amount of blood drawn within the past 30 days for that study: _____mL (if known)

INVESTIGATIONAL STUDIES
Have you ever taken an investigational medication in a clinical trial? ☐ Yes ☐ No

If yes, approximately when was the last dose taken? ____/____/_____

Completed for Study:_____	
Participant Signature_____	**Date_____**
Staff Signature_____	**Date_____**
How did you hear about the study? **Daily Herald** **Craig's List** **Radio station: _____** **Suburban Woman** **Pandora** **Referral** **Twitter** **Google** **Research Chicago** **Facebook** **Email blast** **Other: _____** **Database**	

The Below Signature Boxes For Future Use:

Completed for Study:_____	
Participant Signature_____	**Date_____**
Staff Signature_____	**Date_____**
How did you hear about the study? **Daily Herald** **Craig's List** **Radio station: _____** **Suburban Woman** **Pandora** **Referral** **Twitter** **Google** **Research Chicago** **Facebook** **Email blast** **Other: _____** **Database**	

Name____ Date of Birth ___________________________

Completed for Study:_________________	
Participant Signature____	**Date_____________________**
Staff Signature____	**Date_____________________**
How did you hear about the study? **Daily Herald** **Craig's List** **Radio station: _________** **Suburban Woman** **Pandora** **Referral** **Twitter** **Google** **Research Chicago** **Facebook** **Email blast** **Other: ___________________** **Database**	
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Participant Signature____	**Date_____________________**
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