Medical History

Name: ______________________________________**Initials:** ____________ **DOB:** ____________
First Middle Last

Address: ____
Street City State Zip

Phone #1: __________________**Phone #2:**__________________**Email:**_____________________

Sex: ☐ Male ☐ Female

Do you consider yourself :
☐ Hispanic/Latino or ☐ Not Hispanic/Latino

Which of the five racial designations best describes you:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

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	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Fever of unknown cause				/ /	☐	/ /
Chills				/ /	☐	/ /
Weight loss/ weight gain				/ /	☐	/ /
Loss of appetite				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
SKIN CANCER	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /

Name_______________________________________ Date of Birth ________________

CANCER (All other)	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /
Type:				/ /	☐	/ /
EYES	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Eye Glasses			reading/near-sighted/far-sighted	/ /	☐	/ /
Glaucoma				/ /	☐	/ /
Dry Eyes				/ /	☐	/ /
Cataracts: ☐ R ☐ L ☐ Bilateral				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
EARS	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Hearing Loss: ☐ R ☐ L ☐ Bilateral				/ /	☐	/ /
Ringing/ Buzzing				/ /	☐	/ /
Chronic Ear Infections				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
NOSE OR THROAT	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Sinus Infections				/ /	☐	/ /
Nose Bleeds				/ /	☐	/ /
Chronic Nasal/Sinus congestion				/ /	☐	/ /
Tonsillitis				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
CARDIOVASCULAR	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
High Blood Pressure				/ /	☐	/ /
High Cholesterol				/ /	☐	/ /
High Triglycerides				/ /	☐	/ /

CARDIOVASCULAR (CONT.)	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Heart Murmur				/ /	☐	/ /
Heart Attack				/ /	☐	/ /
Peripheral Vascular Disease (PVD)				/ /	☐	/ /
Angina/ Chest Pain				/ /	☐	/ /
Congestive Heart Failure				/ /	☐	/ /
Arrhythmia/Irregular heart rate				/ /	☐	/ /
Bradycardia				/ /	☐	/ /
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:				/ /	☐	/ /
Other:				/ /	☐	/ /
ENDOCRINE	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Diabetes Type I				/ /	☐	/ /
Diabetes Type II				/ /	☐	/ /
Hyperthyroidism				/ /	☐	/ /
Hypothyroidism				/ /	☐	/ /
Goiter				/ /	☐	/ /
Obesity				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /

Name____ Date of Birth __________________

LUNG / RESPIRATORY	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Asthma				/ /	☐	/ /
Chronic Bronchitis				/ /	☐	/ /
Pneumonia				/ /	☐	/ /
Chronic Cough				/ /	☐	/ /
COPD/Emphysema				/ /	☐	/ /
Shortness of Breath				/ /	☐	/ /
Sleep Apnea				/ /	☐	/ /
Tuberculosis				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
GENITOURINARY	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Kidney Disease				/ /	☐	/ /
Urinary Tract Infections (chronic)				/ /	☐	/ /
Kidney Stones				/ /	☐	/ /
Incontinence/ Bladder Control Problems				/ /	☐	/ /
Sexually Transmitted Disease				/ /	☐	/ /
Low libido				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
Male Conditions ☐ NA if Female	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Premature Ejaculation				/ /	☐	/ /
Enlarged Prostate (BPH)				/ /	☐	/ /
Impotence/Erectile Dysfunction				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
Female Conditions ☐ NA if Male	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Vaginal Infections				/ /	☐	/ /
Abnormal Pap Smear				/ /	☐	/ /

Name____ Date of Birth _________________

Female Conditions (CONT.) ☐ NA if Male	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Abnormal Mammogram				/ /	☐	/ /
Fibrocystic Breast Disease (cysts)				/ /	☐	/ /
Hot Flashes				/ /	☐	/ /
Irregular Menstrual Cycle				/ /	☐	/ /
Postmenopausal (ie. No menses x12 months)			☐ natural or ☐ surgical	/ /	☐	
Difficulty w/ sexual arousal				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
GASTROINTESTINAL	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Liver Disease				/ /	☐	/ /
Hepatitis				/ /	☐	/ /
Gall Bladder Disease				/ /	☐	/ /
Pancreatitis				/ /	☐	/ /
Heartburn				/ /	☐	/ /
Ulcer: (specify type)				/ /	☐	/ /
Recurrent Abdominal Pain				/ /	☐	/ /
Hernia: (specify type)			☐ Inguinal ☐ Ventral ☐ Umbilical ☐ Hiatal	/ /	☐	/ /
Constipation				/ /	☐	/ /
Diarrhea				/ /	☐	/ /
Irritable Bowel Syndrome (IBS)				/ /	☐	/ /
Blood in Stool				/ /	☐	/ /
Hemorrhoids				/ /	☐	/ /
Diverticulosis				/ /	☐	/ /
Diverticulitis				/ /	☐	/ /
Ulcerative Colitis				/ /	☐	/ /
Crohn’s Disease				/ /	☐	/ /
Celiac Disease/Gluten Intolerance				/ /	☐	/ /
Appendicitis				/ /	☐	/ /

Name____ Date of Birth _________________

GASTROINTESTINAL (CONT.)	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Diagnosed Lactose Intolerance				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
SKIN	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Acne (current)				/ /	☐	/ /
Rosacea				/ /	☐	/ /
Atopic Dermatitis / Eczema				/ /	☐	/ /
Cold Sores, Herpes Simplex				/ /	☐	/ /
Psoriasis				/ /	☐	/ /
Recurrent Rashes				/ /	☐	/ /
Bruising				/ /	☐	/ /
Other:				/ /	☐	/ /
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				/ /	☐	/ /

MUSCULOSKELETAL (CONT.)	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Gout				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
IMMUNE SYSTEM	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
HIV				/ /	☐	/ /
Immune Deficiency Disorder				/ /	☐	/ /
Lupus				/ /	☐	/ /
Chronic Fatigue				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
BLOOD DISORDER	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Anemia				/ /	☐	/ /
Clotting / Bleeding problems				/ /	☐	/ /
Low platelets				/ /	☐	/ /
Low White blood cell count				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
NEUROLOGICAL	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Seizure Disorder				/ /	☐	/ /
Insomnia				/ /	☐	/ /
Frequent Headaches				/ /	☐	/ /
Migraines				/ /	☐	/ /
Numbness/ Tingling (location)				/ /	☐	/ /
Multiple Sclerosis				/ /	☐	/ /
Paralysis				/ /	☐	/ /
Tremors				/ /	☐	/ /
Parkinson’s Disease				/ /	☐	/ /
Stroke				/ /	☐	/ /

Name____ Date of Birth __________________

NEUROLOGICAL (CONT.)	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
Transient Ischemic Attack (TIA) or "mini-stroke"				/ /	☐	/ /
Cerebral Hemorrhage				/ /	☐	/ /
Other:				/ /	☐	/ /
Other:				/ /	☐	/ /
PSYCHOLOGICAL	**Yes**	**No**	**Description/Comment**	**Start Date**	**Ongoing**	**Stop Date**
Drug or Alcohol Abuse				/ /	☐	/ /
Depression				/ /	☐	/ /
Anxiety/ Panic Attack(s)				/ /	☐	/ /
Eating Disorder				/ /	☐	/ /
Psychotic Episode(s)				/ /	☐	/ /
Bi-Polar Disorder				/ /	☐	/ /
Schizophrenia				/ /	☐	/ /
Dementia				/ /	☐	/ /
Alzheimer's				/ /	☐	/ /
Other:				/ /	☐	/ /
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
		/ /
		/ /
		/ /

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
		/ /
		/ /
		/ /
		/ /
		/ /

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 *3 MONTHS*.

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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FEMALES ONLY

First day of the last 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__________________________

Name____ Date of Birth ___________________

MALES ONLY

<table>
<tr><th colspan="2">Are you able to father children? ☐ Yes ☐ No</th></tr>
<tr><td>If Yes, please complete below</td><td>If No, please complete below</td></tr>
<tr><td>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):_______________________</td><td>☐ Vasectomy, date____/____/____
☐ Impotent/Erectile Dysfunction
☐ Other____________________________</td></tr>
</table>

SOCIAL HISTORY:

<table>
<tr><th></th><th>Alcohol</th><th>Nicotine</th></tr>
<tr><td>Never Used</td><td>☐</td><td>☐</td></tr>
<tr><td>Ex-User</td><td>☐</td><td>☐</td></tr>
<tr><td>Currently Use</td><td>☐</td><td>☐</td></tr>
<tr><td>Start Date</td><td>/ /</td><td>Please provide details on type, start, and stop date(s):</td></tr>
<tr><td>Stop Date</td><td>/ /</td><td rowspan="2">____ Packs/day ____/____/____ to ____/____/____
____ E-Cigs/day ____/____/____ to ____/____/____
____ Cigars/day ____/____/____ to ____/____/____
____ Pipes/day ____/____/____ to ____/____/____
____ Pinches/day ____/____/____ to ____/____/____
____ Gum/day ____/____/____ to ____/____/____
____ Patches/day ____/____/____ to ____/____/____
____ Other ____/____/____ to ____/____/____</td></tr>
<tr><td></td><td>_____ Drinks/Week
1 drink =
-5oz wine
-12 oz beer
-1oz liquor</td></tr>
</table>

<table>
<tr><th></th><th colspan="2">Caffeine</th><th>Recreational Drug Use</th></tr>
<tr><td>Never Used</td><td colspan="2">☐</td><td>☐</td></tr>
<tr><td>Ex-User</td><td colspan="2">☐</td><td>☐</td></tr>
<tr><td>Currently Use</td><td colspan="2">☐</td><td>☐</td></tr>
<tr><td>Start Date</td><td colspan="2">/ /</td><td>/ /</td></tr>
<tr><td>Stop Date</td><td colspan="2">/ /</td><td>/ /</td></tr>
<tr><td rowspan="2"></td><td>Type</td><td>oz/day</td><td rowspan="2">Please provide details on what drugs used and how:</td></tr>
<tr><td>Example: Diet Coke</td><td>12</td></tr>
</table>

Name____ Date of Birth ___________________

FAMILY HISTORY:(please ONLY list family members WITH the following conditions, or check not applicable)

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

BLOOD DONATION

Have you donated blood or blood components 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______________________**

<u>How did you hear about the study?</u>

Daily Herald
Radio Station:______________
Twitter
Research Chicago
Email Blast
Product Dynamics
Other:___________________
Craig's List
Suburban Woman
Referral
Google
Database
Study Kik

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**
Twitter	**Referral**
Research Chicago	**Google**
Email Blast	**Database**
Product Dynamics	**Study Kik**
Other:___________________	

Completed for Study:__________________	
Participant Signature_____________________________________	**Date______________________**
Staff Signature____	**Date______________________**
How did you hear about the study?	
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Twitter	**Referral**
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Email Blast	**Database**
Product Dynamics	**Study Kik**
Other:___________________	

Completed for Study:__________________	
Participant Signature_____________________________________	**Date______________________**
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Twitter	**Referral**
Research Chicago	**Google**
Email Blast	**Database**
Product Dynamics	**Study Kik**
Other:___________________	