Study: ______________________ Subject Initials __ __ __ Subject ID _________________

<u>**Clinical Research Center**</u>

Medical History

PERSONAL INFORMATION (please print)

Name ____
First Middle Last

Date of Birth _ _/_ _/_ _ _ _ Age ________ □ Male □ Female SSN _ _ _-_ _-_ _ _ _

Address _______________________________ Apt ________
City __________________________________ State _______ Zip ____________

Phone: Home ( ) _____________________ Work ( ) _____________________
Other ( ) _____________________ Specify ________________________

Ethnicity: □ Caucasian □ African American □ Hispanic □ Asian
□ Native American □ Other _________________________

Best day(s) & time(s) for appts: ____
Best time to call you: ____
Can we leave a message in the answering machine? □ Yes □ No

EMERGENCY INFORMATION

Emergency Contact Person ________________________________ Phone _____________
Relationship ____
Address____ Apt _______________
City ________________________________ State _________ Zip _______________

PARTICIPANT AGREEMENT

I understand that NEA Clinic Clinical Research Center will not be providing investigational treatment for my medical condition unless I have qualified for and have entered into a research study. I also understand that if I do enter a study, I will only receive investigational treatment for the medical condition being studied/

Signature _____________________________________ Date ____________________

How did you hear about this study? ____
____
____

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Clinical Research Center

Medical History Questionnaire

Name ____ Age _______
First Middle Last

Height ____ ft. ____ in. Weight: ______lbs. BMI: _____ NEA Clinic Patient Number: __________

CONDITIONS: Check YES or NO column as applicable. Elaborate when necessary. Please include cancers in the organ/ system where applicable.

Condition regarding:	YES	NO	Description/ Comment	Start Date (M/ Y)	Ongoing	End Date (M/ Y)
Head				/	□	/
Ear				/	□	/
Nose				/	□	/
Chronic Sinusitis				/	□	/
Acute Sinusitis				/	□	/
Seasonal Allergic Rhinitis				/	□	/
Eye				/	□	/
Throat				/	□	/
Heart Trouble				/	□	/
High Blood Pressure				/	□	/
High Cholesterol				/	□	/
Asthma/ Bronchitis				/	□	/
Other Breathing Problems				/	□	/
Diabetes				/	□	/
Type I				/	□	/
Type II				/	□	/
HbA1C: ______				/	□	/
30-day Avg. Blood Sugar: ______				/	□	/
Nerve problems				/	□	/
Eye problems				/	□	/
Renal Problems				/	□	/
Thyroid Disease/ Goiter				/	□	/
Liver/ Gallbladder				/	□	/
Ulcer (stomach/ duodenum)				/	□	/
Other Stomach/ Bowel				/	□	/
Kidney/ Bladder				/	□	/
Prostate				/	□	/
Breast				/	□	/
Uterine/ Ovarian/ Cervical				/	□	/
Epilepsy/ Seizures				/	□	/
Stroke/ Nerve				/	□	/
Other Neurological				/	□	/
Arthritis/ Rheumatism				/	□	/
Other Musculoskeletal				/	□	/
Skin				/	□	/
Psychological				/	□	/
Anemia/ Blood				/	□	/
Other Cancers				/	□	/

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SOCIAL HISTORY

Tobacco	**Alcohol**	**Caffeine**
□ **Never Used** □ **Ex-user** □ **Currently use**	□ **Never Used** □ **Ex-user** □ **Currently use**	□ **Never Used** □ **Ex-user** □ **Currently use**
Start Date ___/___/____ **Stop Date** ___/___/____	**Start Date** ___/___/____ **Stop Date** ___/___/____	**Start Date** ___/___/____ **Stop Date** ___/___/____
# cig. pks ________ **/ day** **# cigars** ________**/ day** **# pipefuls** ________ **/day** **# pinches** ________**/ day**	**Beer:** ____ **cans/ week** **Wine:** ____ **glasses/ week** **Liquor:** ____ **drinks/ week**	_____ **oz. / day**

Drug Use: □ **Never Used** □ **Ex-user**

1. **Have you used illicit or recreational drugs in the past 12 months?** □ **No** □ **Yes- date used:** __/__/____
2. **Have you ever been in drug/ alcohol rehabilitation?** □ **No** □ **Yes- date(s):** __/__/____ **to** __/__/____

SURGERIES/ HOSPITALIZATIONS (Mark "S" if surgery, or "H" if hospitalization): List all including childbirth

□ **NONE**

S	**H**		**Date (M/Y)**	**Reason**
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	

ALLERGIES: List all including environment, food, dyes, & medications: □ **NONE**

Allergy	**Reaction**	**Date (M/Y)**
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/
		/

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MEDICATIONS: What over-the-counter, herbal remedies, or prescription medication do you take? □ **NONE**

Medication	Dose	# times/ day	Reason	Start Date (M/Y)	Continuous	End Date (M/Y)
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/
				/	□	/

FOR WOMEN ONLY: Please complete **Section A** or **Section B.** Date of last menstrual period: __/__/____

Section A- ☐ **Able to have children (childbearing potential). Check primary birth control method used.**

	Oral Contracaeptive Pill		Condoms and foam/ gel		Vaginal Condom
	Contraceptive Injection		Diaphragm and foam/ gel		IUD
	Contraceptive Implant		Condoms only		None
	Partner had vasectomy		Abstinence		Other, type:
	Rhythm		Withdrawl		

Section B- ☐ **Non-childbearing by means of (check one and specify date):**

	Hysterectomy	Date: / /
	Tubal Ligation (tubes tied)	Date: / /
	Bilateral Oophorectomy	Date: / /
	Natural Post-Menopause	Date of last natural menstrual period: / /

Please do not sign this form prior to your visit.

Participant Signature ____ **Date** _________________________

Staff Signature ____ **Date** _________________________

**NOTE: All updates must be initialed and dated.*

UPDATES OR ADDITIONAL INFORMATION	Initials	Date