



**This form should take about 5 minutes to complete.
Thanks in advance for completing it.**

Confidential Research Patient Information

Name: First: _____ Middle Initial: _____ Last: _____ **Date:** _____

Age: _____ Date of Birth: _____

Gender (select): Male Female

Race (select): Caucasian African American Native American Asian/Pacific Islander
Hispanic/Latin Other: _____

Contact Numbers:

Primary: _____ Secondary: _____ Email: _____

Home Address:

Street: _____
City: _____ State: _____ Zip Code: _____
Length of Residence here: _____ Who lives with you? _____

Person to notify in case of emergency:

Name: _____ Relationship: _____
Telephone number: _____

Do you have a Primary Physician? Yes No

If Yes: Name: _____
Address: _____
Telephone Number: _____

Do you have health insurance? Yes No

How did you hear about the Research Center? (select) Web Paper Radio TV
Referral Other

I. PERSONAL HABITS:

When was the last time that you used recreational drugs (e.g. marijuana, cocaine, methamphetamine, etc.)? Please select:

last week last month last year last 5 years last 10 years over 10 years never

II. LEGAL HISTORY:

Are you currently involved in a legal dispute? No _____ Yes _____ If yes, please explain:

Have you ever been arrested? No _____ Yes _____ If yes, please explain:

III. EDUCATION AND WORK HISTORY:

Less than High School _____ High School/GED _____ Some college _____ College Grad _____

While attending school, what grades do/did you typically earn? A B C D F

Are you currently employed? Yes No Hours worked per week: _____

What is your job? _____ How long have you had this job? _____

How many jobs have you had in the last ten years? _____ Length of longest job: _____

Have you ever served in the military? Yes No What branch? _____ When? _____

IV. CONTRACEPTION:

Current method of birth control (check all that apply):

Condom and Foam/gel Diaphragm and foam/gel Birth control pills Depo Provera Norplant

Hysterectomy Menopause Tubal ligation Vasectomy Abstinence

Other(specify): _____

Thank you for completing this confidential form. You will have the opportunity to discuss your answers when you meet with your doctor.

For staff use only: Date reviewed with clinician: _____

All entries in _____ ink made by _____ upon review with the patient

Medical History Questionnaire

Name: _____

Date: _____

DOB: _____

Please check <u>yes</u> or <u>no</u> for each condition listed below					
<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Description / Comment</u>	<u>Start Date</u>	<u>Stop Date</u>
Ear, Nose, Throat Disease?					
Eye Disease?					
Thyroid Disease / Goiter?					
Heart Disease?					
High Blood Pressure?					
High Cholesterol?					
Lung Disease?					
Diabetes?					
Liver / Gallbladder Disease?					
Stomach / Intestinal Disease?					
Kidney / Bladder Disease?					
Prostate Disease?					
Breast Disease?					
Uterine / Ovarian/ Cervical Disease?					
Epilepsy / Seizures/ Stroke or TIA?					
Neurological Disease?					
Bone or Joint Disease?					
Skin Disease?					
Psychological Problems?					
Blood Disease?					
Cancer or Tumors?					
Current method of birth control?					
Other?					

Medical History Questionnaire

SURGERIES or HOSPITALIZATIONS:

None

Surgery / Hospitalization	Date	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES: Please list all including environmental, food, & medication

None

Allergy	Reaction	Date Started	Date Ended
		_____	_____
		_____	_____
		_____	_____

MEDICATIONS: What over-the-counter or prescription medications, including vitamins and herbal preparations, have you taken in the last 3 months?

None:

	Dose	# Times / Day	Reason	Start Date	Stop Date	Cont'd?

Reviewed by:	Date:
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