SUMMIT RESEARCH

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**

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 | Diaphram 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					
Condition	**Yes**	**No**	**Description / Comment**	**Start Date**	**Stop Date**
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: