bfhc research

# Medical History Form

_____ _____ _____
Subject Initials

**Demographics**

Name: ______________________________________________________________________________
First    Middle Initial    Last    (suffix)

Street Address: ________________________________________________________________________

______________________________ ______________________ ______________________
City    State    Zip

Primary Phone: (________) __________________ (Home /Cell)

Alternate Phone: (________) ________________ (Home /Cell)

e-mail Address: ______________________________________________

Driver License # ________________________________________ State: ____________

Date of Birth: _______ / _______ / ___________    Age: ________    Gender: ☐Male ☐Female
Month    Day    Year

| **Race** | ☐American Indian or Alaska Native ☐Asian ☐Black or African American<br>☐White ☐Native Hawaiian or other Pacific Islander ☐Other (Specify):_______________ |
|---|---|
| **Ethnic Group:** | ☐ Hispanic or Latino ☐ Not Hispanic or Latino |

Have you previously participated in an Investigational Trial?
☐No
☐Yes, Date completed last trial: _____/_____/_____ Date last dose of Study Drug taken: _____/_____/_____

**Emergency Contact:**

Name:_________________________________ Relationship:_________________________________

Phone: (___)_______-________ May we discuss your medical information with this person? ☐No ☐Yes

Do you have a Primary Care Physician? ☐No ☐Yes, complete information below

Do you want us to notify your PCP of your participation in any Clinical Research Studies you are enrolled in?

☐No ☐Yes: Physician's Name: ______________________________ Phone #: (____) _______ - ___________

How did you hear about this research study?

Are you related to any staff member at BFHC Research? ☐No ☐Yes, ________________________

| No | YES | Cardiac | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | High Blood Pressure / Hypertension | | | |
| ☐ | ☐ | High Cholesterol | | | |
| ☐ | ☐ | High Triglycerides | | | |
| ☐ | ☐ | Chest Pain / Angina | | | |
| ☐ | ☐ | Coronary Artery Disease | | | |
| ☐ | ☐ | Heart Attack / Myocardial Infarction | | | |
| ☐ | ☐ | Congestive Heart Failure | | | |
| ☐ | ☐ | Heart Murmur | | | |
| ☐ | ☐ | Deep Vein Thrombus | | | |
| ☐ | ☐ | Peripheral Vascular Disease | | | |
| ☐ | ☐ | Mini Stroke / TIA | | | |
| ☐ | ☐ | Stroke / CVA | | | |
| ☐ | ☐ | Cardiac Arrhythmia | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Gastrointestinal | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Acid Reflux / GERD | | | |
| ☐ | ☐ | Gastric Ulcer | | | |
| ☐ | ☐ | Colon Polyps | | | |
| ☐ | ☐ | Irritable Bowel Syndrome | | | |
| ☐ | ☐ | Gastroparesis | | | |
| ☐ | ☐ | Chronic Diarrhea | | | |
| ☐ | ☐ | Chronic Constipation | | | |
| ☐ | ☐ | Gall Stones / Cholelithiasis | | | |
| ☐ | ☐ | Hepatitis ☐A ☐B ☐C | | | |
| ☐ | ☐ | Fatty Liver | | | |
| ☐ | ☐ | Cirrhosis | | | |
| ☐ | ☐ | Diverticulosis | | | |
| ☐ | ☐ | Diverticulitis | | | |
| ☐ | ☐ | Crohn's Disease | | | |
| ☐ | ☐ | Ulcerative Colitis | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Hematologic | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Anemia | | | |
| ☐ | ☐ | Clotting Disorder | | | |
| ☐ | ☐ | Blood Cancer | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Respiratory | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Asthma | | | |
| ☐ | ☐ | COPD | | | |
| ☐ | ☐ | Emphysema | | | |
| ☐ | ☐ | Chronic Bronchitis | | | |
| ☐ | ☐ | Obstructive Sleep Apnea | CPAP use? ☐No ☐Yes | | |
| ☐ | ☐ | Shortness of Breath / Dyspnea | | | |
| ☐ | ☐ | Snoring | | | |
| ☐ | ☐ | Persistent coughing | | | |
| ☐ | ☐ | Pulmonary Embolus | | | |
| ☐ | ☐ | Pneumonia | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Female Reproductive<br>☐N/A - Male | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Irregular menstrual cycle | | | |
| ☐ | ☐ | Endometriosis | | | |
| ☐ | ☐ | Uterine fibroids | | | |
| ☐ | ☐ | Ovarian cyst | | | |
| ☐ | ☐ | Polycystic Ovarian Syndrome | | | |
| ☐ | ☐ | Genital warts | | | |
| ☐ | ☐ | Vaginal dryness | | | |
| ☐ | ☐ | Vaginal yeast infection (frequent) | | | |
| ☐ | ☐ | Post-Menopausal | | | |
| ☐ | ☐ | Sexually Transmitted Disease | | | |
| ☐ | ☐ | Other: | | | |
| Method of Contraception: | | | | | |
| Date of Last Menstrual Cycle: _____/_____/_____ | | | | | |

| No | YES | Male Reproductive<br>☐N/A - Female | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | BPH / Enlarged Prostate | | | |
| ☐ | ☐ | Erectile Dysfunction | | | |
| ☐ | ☐ | Sexually Transmitted Disease | | | |
| ☐ | ☐ | Low Testosterone | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Genitourinary | Specifics, if any | Start Date | End Date<br>"ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Overactive Bladder | | | |
| ☐ | ☐ | Urinary Incontinence | | | |
| ☐ | ☐ | Frequent UTIs | | | |
| ☐ | ☐ | Kidney Stones | | | |
| ☐ | ☐ | Kidney Failure | | | |
| ☐ | ☐ | Other: | | | |

 CRC Initials________

| No | YES | Immunologic | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | HIV / AIDS | | | |
| ☐ | ☐ | Auto Immune Disease | | | |
| ☐ | ☐ | Environmental Allergies | | | |
| ☐ | ☐ | Other: | | | |
| ☐ | ☐ | Drug Allergies | Describe Reaction | | |
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| No | YES | Musculoskeletal | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Back Pain | | | |
| ☐ | ☐ | Bone Fractures | | | |
| ☐ | ☐ | Fibromyalgia | | | |
| ☐ | ☐ | Gout | | | |
| ☐ | ☐ | Osteoarthritis | | | |
| ☐ | ☐ | Rheumatoid Arthritis | | | |
| ☐ | ☐ | Osteoporosis | | | |
| ☐ | ☐ | Chronic Pain | | | |
| ☐ | ☐ | Bunion Deformity | | | |
| ☐ | ☐ | Hammertoe Deformity | | | |
| ☐ | ☐ | Other: | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Neurologic | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | | | |
| ☐ | ☐ | Migraine Headaches | | | |
| ☐ | ☐ | Insomnia | | | |
| ☐ | ☐ | Restless Leg Syndrome | | | |
| ☐ | ☐ | Peripheral Neuropathy | | | |
| ☐ | ☐ | Epilepsy | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | Psychiatric | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Anxiety | | | |
| ☐ | ☐ | Depression | | | |
| ☐ | ☐ | Bipolar | | | |
| ☐ | ☐ | Schizophrenia | | | |
| ☐ | ☐ | ADD | | | |
| ☐ | ☐ | ADHD | | | |
| ☐ | ☐ | Other: | | | |

 CRC Initials________

| No | YES | Endocrine | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes Mellitus | ☐Type I ☐Type II ☐Gestational | | |
| ☐ | ☐ | Hypothyroidism | | | |
| ☐ | ☐ | Hyperthyroidism | | | |
| ☐ | ☐ | Addison's Disease | | | |
| ☐ | ☐ | Graves Disease | | | |
| ☐ | ☐ | Metabolic Syndrome | | | |
| ☐ | ☐ | Obesity | | | |
| ☐ | ☐ | Other: | | | |
| ☐ | ☐ | Current Weight Loss Program? | | | |

| No | YES | Dermatologic | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Tinea Pedis | | | |
| ☐ | ☐ | Acne | | | |
| ☐ | ☐ | Eczema | | | |
| ☐ | ☐ | Psoriasis | | | |
| ☐ | ☐ | Rosacea | | | |
| ☐ | ☐ | Diabetic Foot Ulcer | | | |
| ☐ | ☐ | Toenail Fungus / Onychomycosis | | | |
| ☐ | ☐ | Other: | | | |

| No | YES | HEENT | Specifics, if any | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|---|---|
| ☐ | ☐ | Cataract(s) | | | |
| ☐ | ☐ | Glaucoma | | | |
| ☐ | ☐ | Diabetic Retinopathy | | | |
| ☐ | ☐ | Macular Degeneration | | | |
| ☐ | ☐ | Hearing Loss | | | |
| ☐ | ☐ | Tinnitus / Ringing in the ears | | | |
| ☐ | ☐ | Frequent Sinusitis | | | |
| ☐ | ☐ | Tonsillitis | | | |
| ☐ | ☐ | Corrected Vision | ☐Myopia ☐Hyperopia ☐Presbyopia | | |
| ☐ | ☐ | Other: | | | |

| Tobacco / Alcohol / Drug Use | | Start Date | End Date "ONG" if ongoing |
|---|---|---|---|
| **Tobacco Use:** | ☐Never ☐Current use, complete below ☐Past Use, complete below<br>Tobacco Products: ☐Cigarettes ☐Cigar ☐Pipe ☐Smokeless ☐Vapor<br>Amount Used: ______________________ per: __________________ | | |
| **Recreational Drug Use:** | ☐Never ☐Current use, complete below ☐Past Use, complete below<br>Describe: ____________________________________________ | | |
| **Alcohol Use:** | ☐Never ☐Current use, complete below ☐Past Use, complete below<br>☐Beer :_______________per: ☐week ☐Month ☐Year<br>☐Liquor:_______________per: ☐week ☐Month ☐Year<br>☐Wine:_______________per: ☐week ☐Month ☐Year | | |

| **Surgical History** ☐N/A – no prior surgeries | | | | |
|---|---|---|---|---|
| **Surgical Procedure Performed** *(indicate right or left, if applicable)* | **Date of Surgery** | **Reason (Diagnosis) for Surgery** | **Start Date** | **End Date** |
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| **Medication/Vitamin/Herbal Supplement History** ☐N/A – no medications | | | | | | |
|---|---|---|---|---|---|---|
| **Name of Medication** | **Dose / Unit** | **Frequency** | **Route** | **Reason Taking** | **Start Date** | **End Date** **"ONG" if ongoing** |
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**I verify that the information I have provided in this Medical History is true and complete to the best of my knowledge.**

_______________________________________________________ _____/_____/_____
Patient Signature Date

_______________________________________________________ _____/_____/_____
Signature of CRC reviewing Form Date

_______________________________________________________ _____/_____/_____
Signature of Investigator reviewing Form Date