Patient Demographics

The following information is required for our files. Press the Tab key to advance to each field.
You may also print the form to a printer and complete it by hand. PLEASE PRINT

Last name:		First name		Middle Initial	

Today's Date ______ Date of Birth ______ Social Security # ______ ☐Male ☐Female

Address ______ Email Address ______

City: ______ State: ______ Zip Code: ______

Phone # for reminder calls ______ Alternate Phone ______

Emergency Contact ______

Relationship ______ Phone ______

Family Physician ______ Phone ______

Were you referred to us by a physician? ☐Yes ☐No If Yes, name of physician ______

Race
☐Caucasian
☐African American
☐Hispanic
☐Asian
☐Other (Specify)

Marital Status
☐Single
☐Married
☐Divorced
☐Widowed
☐Separated

Number of Children

Current medications

Include psychiatric meds, Tylenol, Advil, herbals, multivitamins. etc.

Medication Name	Dose (mg)	Frequency (every day, 1/week, etc)	Reason for Use	Start Date	End date

Allergies

Medication	Reaction	Date
Medication	Reaction	Date
Medication	Reaction	Date

Additional notes

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Please check all that apply. Include start and stop dates.

Cardiovascular — DATES

- ☐ Chest pain ______
- ☐ Irregular Heart Beat ______
- ☐ Hypertension ______
- ☐ High Cholesterol ______
- ☐ By-pass surgery ______
- ☐ Stint or artificial valve ______

Gastrointestinal

- ☐ Stomach bypass (for weight reduction) ______
- ☐ Gallbladder ______
- ☐ Heartburn ______
- ☐ Irritable bowel ______
- ☐ Chronic diarrhea (Crohns) ______
- ☐ Ulcers ______

Hepatic /Renal

- ☐ Hepatitis ______
- ☐ Jaundice ______
- ☐ Kidney stones ______
- ☐ Kidney infections ______
- ☐ Liver problems ______

Musculoskeletal

- ☐ Arthritis ______
- ☐ Muscle problems ______
- ☐ Gout ______
- ☐ Bone fractures ______

Respiratory

- ☐ Asthma ______
- ☐ Bronchitis ______
- ☐ Lung disorder ______
- ☐ Seasonal allergies ______
- ☐ Emphysema ______
- ☐ Pneumonia ______

Dermatologic — DATES

- ☐ Cyst (related to skin conditions): ______
- ☐ Skin conditions ______
- ☐ Tumors ______
- ☐ Skin Cancer ______
- ☐ Melanoma ______

Genito / Urinary

- ☐ Bladder infections ______
- ☐ Prostate problems ______
- ☐ Fibroids ______
- ☐ Cysts ovarian ______
- ☐ Low sex drive ______

Lymphatic /Hematopoietic

- ☐ Anemia ______
- ☐ Bleeding problems ______
- ☐ Cancer ______
- ☐ Sickle cell anemia ______

Ears, Eyes, Nose, Throat

- ☐ Eye problems ______
- ☐ Glaucoma ______
- ☐ Sinusitis ______
- ☐ Ear problems ______

Endocrine

- ☐ Diabetes ______
- ☐ Thyroid Problems ______

Neurological

- ☐ Headaches ______
- ☐ Migraines ______
- ☐ Seizures/epilepsy ______
- ☐ Head injury or trauma ______
- ☐ Meningitis ______
- ☐ Insomnia ______
- ☐ Depression ______
- ☐ Anxiety ______

History of Alcohol:

Do you drink? ☐ Yes ☐ No

If Yes How often do you drink? ☐ Daily ☐ Weekends ☐ Occasionally

What do you drink when you do? ☐ Beer ☐ Wine ☐ Liquor

If No, are you a previous drinker? ☐ Yes ☐ No **Stop date:** ______

History of smoking

Do you smoke? ☐ Yes ☐ No

If Yes, How many years?

How many packs a day?

If No, are you a previous smoker? ☐ Yes ☐ No **Stop date** ______

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Use of non-prescribed drugs & substances

Do you use drugs (including marijuana, crack, heroin) ☐Yes ☐No

If Yes

What drugs or substances	How often	First Use	Last Use

Psychiatric Medications (previous medications)

Medication Name	Times per day	Start date	End date

Surgeries (any type)

Type	Date
Type	Date
Type	Date
Type	Date
Type	Date
Type	Date

Have you ever been in treatment for alcohol or drug abuse or dependence? ☐Yes ☐No

Dates: ______________________

How long:

Where:

Females Only

Last menstrual cycle ______ Method of Birth Control ______ Length of use ______

Number of Births ______ Vaginal ______ C-Section ______

Pap Smear ☐Yes ☐No Date of last exam ______

Histerectomy ☐Yes ☐No ______ Date

Mammogram ☐Yes ☐No Date of last exam ______

Ovaries removed ☐Yes ☐No ______ Date

Menapause ☐Yes ☐No ______ Date

Education Level Last completed grade of formal education ______

Living Arrangements
- ☐Live Alone
- ☐With Family
- ☐Spouse
- ☐Significant Other

Employed?
- ☐Yes
- ☐Full Time
- ☐Part Time
- ☐No
- ☐Looking for work
- ☐Retired
- ☐Homemaker
- ☐Student

Occupation: ______

Why are you participating in a study? ______

How did you hear about the study? ______

What newspaper do you read regularly? ______

What radio stations do you listen to regularly? ______

Do you watch TV? ☐light ☐average ☐heavy

Do you use public transportation? ☐Yes ☐No

Additional Comments:

______

______

______

______

Participant's Signature ______ **Coordinator's Initials** ______

PI / Sub-I Signature ______