HWC WOMEN'S RESEARCH CENTER

Patient Demographics and Medical History

Last name:		First name		Middle Initial	

Today's Date_____ **Date of Birth** _____ ☐Male ☐Female

Address _____ Email Address _____

City: _____ **State:** _____ **Zip Code:** _____

Phone # for reminder calls _____ **Alternate Phone** _____

Emergency Contact _____

Relationship _____ **Phone** _____

Family Physician _____ **Phone** _____

How did you hear about us? _____

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

Hispanic/Non-Hispanic

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

Current medications

Please include any OAB Meds taken within the previous i year

Include all Prescription and Over-the-Counter medications..

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**

Patient Demographics and Medical History

Please check all that apply. Include start and stop dates. (INCLUDE FROM PREVIOUS 5 YEARS TO CURRENT)

Cardiovascular	DATES
☐ Chest pain	
☐ Irregular heart beat	
☐ High cholesterol	
☐ By-pass surgery	
☐ Stint or artificial valve	
☐ Blood clot	
☐ Deep venous thrombosis	
Gastrointestinal	
☐ Stomach bypass (lap-band, etc)	
☐ Gallbladder	
☐ Heartburn	
☐ Irritable bowel	
☐ Chronic diarrhea (crohns)	
☐ Ulcers	
Hepatic/Renal	
☐ Hepatitis	
☐ Jaundice	
☐ Kidney stones	
☐ Kidney infections	
☐ Liver problems	
Muskuloskeletal	
☐ Arthritis	
☐ Muscle problems	
☐ Gout	
☐ Bone fractures	
Respiratory	
☐ Asthma	
☐ Bronchitis	
☐ Lung disorder	
☐ Seasonal allergies	
☐ Emphysema	
☐ Pneumonia	
Other Illness	
☐ _____	
☐ _____	
☐ _____	
☐ _____	
☐ _____	
☐ _____	

Neurological	DATES
☐ Headaches/ Migraines	
☐ Anxiety	
☐ Seizures/epilepsy	
☐ Head injury or trauma	
☐ Meningitis	
☐ Insomnia	
☐ Depression	
Genito/Urinary	
☐ Bladder infections	
☐ Prostate problems	
☐ Fibroids	
☐ Cysts ovarian	
☐ Low sex drive	
Lymphatic/Hematopoietic	
☐ Anemia	
☐ Bleeding problems	
☐ Sickle cell anemia	
Ear, Eyes, Nose, Throat	
☐ Eye problems	
☐ Glaucoma	
☐ Sinusitis	
☐ Ear problems	
Dermatologic	
☐ Cyst	
☐ Skin conditions	
☐ Tumors	
☐ Skin cancer	
☐ Melanoma	
Cancers	
☐ _____	
☐ _____	
☐ _____	
☐ _____ Trauma	
☐ _____	
☐ _____	

Patient Demographics and Medical History

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 _____

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

Surgeries within the past 5 years (any type)

Type	Date
Type	Date
Type	Date
Type	Date
Type	Date

Patient Demographics and Medical History

Females Only

Last menstrual cycle _____ Method of birth control _____ Start Date: _____

Number of births _____ Vaginal _____ C-Section _____

Abortions _____ Miscarriages _____

Pap smear ☐ Yes ☐ No Date of last exam _____

Mammogram ☐ Yes ☐ No Date of last exam _____

Hysterectomy ☐ Yes ☐ No Date _____

Ovaries removed ☐ Yes ☐ No Date _____

Menopause ☐ Yes ☐ No Date _____

Methods of birth control within the past year _____ _____ _____ Length of use _____ _____ _____

Education level **Last completed grade of formal education** _____

Employed?

☐ Yes ☐ Full time ☐ Part time ☐ No

☐ Looking for work ☐ Retired ☐ Homemaker ☐ Student

Occupation: _____

Additional Comments:

_____

_____

_____

Participant's Signature _____ **Coordinator's Initials** _____

PI / Sub-I Signature _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby grant my permission to release any and all required medical records from:

Dr's Name _____
Dr's Address _____

_____

Doctor's Phone: (_____)_____-_____

To be released to:

Stuart A Weprin, MD
HWC Women's Research Center
20 W. Wenger Road
Englewood, OH 45322
Phone: (937) 771-5103 -- Fax: (937) 771-5109

For the purpose of participating in a clinical trial regarding the following diagnoses:

_____

Type of information to be disclosed:
Any and all medical records with pertinent medical information*
Amount of information to be disclosed:
Any and all information covering a minimum of the past 1(one) year*

By signing below, I understand that the information I authorize HWC to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to participate in any clinical trials. I understand that this authorization may be withdrawn at any time in writing. This authorization will be in effect for 180 days after I sign and date the form below unless I specify an earlier expiration date in this space_____.

Please PRINT full name: _____

Date of Birth____/___/____

Address _____

City: _____ **State** _____ **Zip** _____

Phone (_____)_____- _____

_____
Client Signature/Person authorized to give consent/Guardian **Relationship to client**

Date____/____/____

_____
Signature of staff member facilitating request **Date**

*__**Please note**__: This information will be disclosed to HWC from records pr otected by federal confidentiality rules. The federal rules prohibit HWC from making any further disclos ure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.