Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Participant History Form

Date of appointment ____/____/_____ Time of appointment ____:_____ □ am □ pm

Name _____

Birthdate: ____/____/_____ Age: _____

Address:_____

City:_____ State:_____ Zip:_____

Contact number: (_____) _____-_____ ☐Home ☐Cell ☐Work

Alternate number: (_____) _____-_____ ☐Home ☐Cell ☐Work

Email address: _____

Best days(s) and time(s) for appointments:_____

Best time of day to contact you:_____ Best method of contact: ☐Home ☐Email ☐Cell ☐Work

May we leave a message on your answering machine: ☐ Yes ☐ No

Emergency Contact Information:

Contact's Name _____

Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Contact number: (_____) _____-_____ ☐Home ☐Cell ☐Work

Alternate number: (_____) _____-_____ ☐Home ☐Cell ☐Work

May we leave a message with this person: ☐ No ☐ Yes or Yes with Exclusions:

_____

Primary Care Physician:

Name of Physician: _____ Phone: _____

Address: _____

Would you like your primary care physician notified of any clinical trials you participate in with MCRC?

☐ Yes☐ No

CLINIC USE ONLY

Date PCP letter sent: _____/_____/_____ ☐N/A

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Sex: ☐ Male ☐ Female

Ethnicity: (*Check the box with who you most identify)*

☐ American Indian/Alaskan ☐ White
☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ Other - Specify:
☐ Hispanic

Referred here by: (Check one)

☐ Self ☐ Family ☐ Friend ☐ Primary Care Physician
☐ Physician, other: _____
☐ Health Professional, other: _____

Current Symptoms of Disease and Medical History:

What is the primary reason for your visit today:

_____

_____

Date your symptoms began (approximate): _____/_____/_____

Date you started being treated for this diagnosis: _____/_____/_____

Treatments you have received or are currently receiving for this diagnosis?

_____

_____

_____

Who have you seen for treatment?

_____

******For Medication and Medical History if unsure of start/ onset date, please provide your best estimate.***

Current Medications	Dose	Reason for Use	Date Started

Please check the box under “medical history” if you have ever been diagnosed with any of the following. If you are currently taking any medication for that condition check the box for “taking medication”. We understand it may be hard to remember the exact date the condition started. If necessary, please estimated as closely as possible the year of diagnoses.

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)	Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)
AUTOIMMUNE DISEASE ☐ *No conditions reported*							
☐	Sjogren's Syndrome		☐ N/A	☐	Sub-acute Cutaneous Lupus erythematosus		☐ N/A
☐	Psoriatic Arthritis		☐ N/A	☐	Systemic Lupus erythematosus		☐ N/A
☐	Rheumatoid Arthritis		☐ N/A	☐	Giant Cell Arteritis		☐ N/A
☐	Discoid Lupus erythematosus		☐ N/A	☐	Other:		☐ N/A
☐	HIV Positive		☐ N/A				
BLOOD DISORDER ☐ *No conditions reported*							
☐	Anemia		☐ N/A	☐	Leukopenia		☐ N/A
☐	Thrombocytopenia (decreased platelets)		☐ N/A	☐	Other:		☐ N/A
CANCER/MALIGNANCY ☐ *No conditions reported*							
☐	Type:						☐ N/A
☐	Type:						☐ N/A
CARDIOVASCULAR ☐ *No conditions reported*							
☐	Arrythmia/ Abnormal ECG (specify):		☐ N/A	☐	Myocardial Infarction (heart attack)		☐ N/A
☐	Angina (chest pain)		☐ N/A	☐	High cholesterol		☐ N/A
☐	Congestive Heart Failure		☐ N/A	☐	Hyperlipidemia		☐ N/A
☐	Coronary Artery Disease		☐ N/A	☐	High blood pressure		☐ N/A
☐	Carotid Stenosis		☐ N/A	☐	Other:		☐ N/A
☐	Heart Murmur		☐ N/A				
EARS ☐ *No conditions reported*							
☐	Vertigo		☐ N/A	☐	Hearing Disorder		☐ N/A
☐	Hearing Loss (specify location)		☐ N/A	☐	Other:		☐ N/A

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)	Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)
ENDOCRINE/METABOLIC ☐ *No conditions reported*							
☐	Diabetes Type I		□ N/A	☐	Hashimoto's Thyroiditis		□ N/A
☐	Diabetes Type II		□ N/A	☐	Hyperthyroidism		□ N/A
☐	Cushing's Syndrome		□ N/A	☐	Hypothyroidism		□ N/A
☐	Adrenal Suppression		□ N/A	☐	Vitamin D Deficiency		□ N/A
☐	Iron Deficiency		□ N/A	☐	Other:		□ N/A
EYES ☐ *No conditions reported*							
☐	Astigmatism		□ N/A	☐	Myopia (nearsightedness)		□ N/A
☐	Cataract (vision disturbance)		□ N/A	☐	Uveitis		□ N/A
☐	Hyperopia (farsightedness)		□ N/A	☐	Episcleritis		□ N/A
☐	Dry eyes		□ N/A	☐	Amaurosis Fugax		□ N/A
☐	Glaucoma		□ N/A	☐	Macular Degeneration		□ N/A
GASTROINTESTINAL ☐ *No conditions reported*							
☐	Hemorrhoids		□ N/A	☐	Gastrointestinal Bleeding		□ N/A
☐	Blood in Stool		□ N/A	☐	GERD		□ N/A
☐	Cholecystitis		□ N/A	☐	Heartburn		□ N/A
☐	Cholelithiasis (galllstones)		□ N/A	☐	Acid Reflux		□ N/A
☐	Chronic Constipation		□ N/A	☐	Hepatitis (specify type):		□ N/A
☐	Chronic Diarrhea		□ N/A	☐	Hernia (specify location):		□ N/A
☐	Chronic Vomiting		□ N/A	☐	Fatty Liver		□ N/A
☐	Diverticulitis		□ N/A	☐	Irritable Bowel Syndrome		□ N/A
☐	Elevated Liver Enzymes		□ N/A	☐	Nausea		□ N/A
☐	Inflammatory Bowel Disease (specify type) _____		□ N/A	☐	Recurrent Abdominal Pain		□ N/A
☐	Gastric Ulceration (specify type) _____		□ N/A	☐	Other:		□ N/A

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)	Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)
GENITOURINARY ☐ *No conditions reported*							
☐	Benign Prostatic Hyperplasia (BPH)		☐ N/A	☐	Chronic Renal Disease		☐ N/A
☐	Herpes Simplex Type 2 (genital)		☐ N/A	☐	Incontinence		☐ N/A
☐	Chronic Hematuria		☐ N/A	☐	Kidney Stone		☐ N/A
☐	Erectile Dysfunction		☐ N/A		Other:		
☐	Sexually Transmitted Disease (specify type):		☐ N/A	☐			☐ N/A
GYNECOLOGICAL ☐ *No conditions reported* ☐ N/A – Male							
☐	Abnormal Mammogram		☐ N/A	☐	Hot Flashes		☐ N/A
☐	Breast Cysts		☐ N/A	☐	Irregular Menstrual Cycle		☐ N/A
☐	Breast Lumps		☐ N/A	☐	Other:		☐ N/A
INTEGUMENTARY ☐ *No conditions reported*							
☐	Acne		☐ N/A	☐	Psoriasis		☐ N/A
☐	Atopic Dermatitis		☐ N/A	☐	Recurrent Rashes		☐ N/A
☐	Eczema		☐ N/A	☐	Rosacea		☐ N/A
☐	Herpes Simplex Type 1 (cold sores)		☐ N/A		Other:		
☐	Herpes Zoster (Shingles)		☐ N/A	☐			☐ N/A
MUSCULOSKELETAL ☐ *No conditions reported*							
☐	Fibromyalgia		☐ N/A	☐	Carpal Tunnel Syndrome (specify location):		☐ N/A
☐	Fractured Bones		☐ N/A				
☐	Gout		☐ N/A	☐	Osteoporosis		☐ N/A
☐	Leg Cramps		☐ N/A	☐	Recurrent Back Pain		☐ N/A
☐	Osteoarthritis		☐ N/A	☐	Recurrent Joint Pain		☐ N/A
☐	Osteopenia		☐ N/A	☐	Other:		☐ N/A

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)	Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)
NOSE or THROAT ☐ *No conditions reported*							
☐	Seasonal Allergies		□ N/A	☐	Nasal Congestion		□ N/A
☐	Deviated Septum		□ N/A	☐	Sinus Congestion		□ N/A
☐	Nose Bleeds		□ N/A	☐	Other:		□ N/A
NEUROLOGICAL ☐ *No conditions reported*							
☐	Cerebral Accident/ Stroke (specify type):		□ N/A	☐	Seizures (specify type):		□ N/A
☐	Transient Ischaemic Attack		□ N/A	☐	Tingling (specify location):		□ N/A
☐	Diabetic Neuropathy		□ N/A				
☐	Insomnia		□ N/A	☐	Multiple Sclerosis		□ N/A
☐	Migraines		□ N/A	☐	Numbness (specify location)		□ N/A
☐	Headaches (specify type)		□ N/A	☐	Paralysis (specify location)		□ N/A
☐	Dizziness		□ N/A	☐	Parkinson's Disease		□ N/A
☐	Lightheadedness		□ N/A	☐	Tremors		□ N/A
☐	Epilepsy		□ N/A	☐	Other:		□ N/A
PSYCHOLOGICAL ☐ *No conditions*							
☐	Alzheimer's Disease		□ N/A	☐	Substance Abuse (specify)		□ N/A
☐	Anxiety		□ N/A				
☐	Bipolar Disorder		□ N/A	☐	Panic attacks		□ N/A
☐	Dementia		□ N/A	☐	Psychotic Episodes		□ N/A
☐	Depression		□ N/A	☐	Schizophrenia		□ N/A
☐	Eating Disorder		□ N/A	☐	Other:		□ N/A

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)	Medical History	Condition	Start Date	Stop Date (Check N/A if ongoing)
RESPIRATORY ☐ *No conditions reported*							
☐	Asthma		□ N/A	☐	Pneumonia		□ N/A
☐	Interstitial Lung Disease		□ N/A	☐	Shortness of Breath		□ N/A
☐	Chronic Cough		□ N/A	☐	Sleep Apnea		□ N/A
☐	COPD		□ N/A	☐	Other:		□ N/A
☐	Tuberculosis		□ N/A				
CHRONIC INFECTIONS ☐ *No conditions*							
☐	Chronic Ear Infections		□ N/A	☐	Chronic Eye Infections		□ N/A
☐	Chronic Yeast infections		□ N/A	☐	Chronic fungal infections		□ N/A
☐	Chronic Respiratory Infection/ Bronchitis		□ N/A	☐	Chronic Kidney Infection		□ N/A
☐	Chronic Bladder Infection		□ N/A	☐	Chronic Vaginal Infection		□ N/A
☐	Chronic Throat Infections		□ N/A	☐	Chronic Urinary Tract Infections		□ N/A
☐	Chronic Sinus Infections		□ N/A	☐	Other:		□ N/A
GENERAL/ OTHER ☐ *No conditions reported*							
☐	Obesity		□ N/A	☐	Raynaud's Phenomenon		□ N/A
☐	Other:		□ N/A	☐	Other:		□ N/A
REPRODUCTIVE STATUS ☐ *No conditions reported*							
Is patient of non-childbearing potential or a sterilized male? Yes □ No □* (see below) (post-menopausal ≥ 1yr or post vasectomy ≥6 mo or hysterectomy, ooperectomy or tubal ligation) If "No", indicate the form of birth control currently used:_____							
☐	Bi-lateral Oopherectomy	Date of procedure:		☐	Tubal Ligation	Date of procedure:	
☐	Vasectomy with confirmation **(MALES ONLY)**	Date of procedure:		☐	Post-Menopausal	Date of last period:	
				☐	Hysterectomy	Date of procedure:	

Patient Initials/ Date	

PARTICIPANT REGISTRATION AND INTAKE FORM

VACCINATION HISTORY		
☐	BCG (TB Vaccination)	Received Date:
☐	Pneumovax	Received Date:
☐	Flu	Received Date:
☐	Other:	Received Date:

ALLERGY	REACTION	DATE

S	SURGERY/ HOSPITALIZATION (Check S for surgery in box to left)	REASON	DATE
☐			
☐			
☐			
☐			
☐			
☐			

I have reviewed the information in the patient's intake form in full, discussed the information with the patient, and clarified information in a research chart note as necessary.

Coordinator Signature _____ Date _____

Investigator Signature _____ Date _____