

Study Patient Questionnaire

Patient Name _____ **Birth Date** _____
mm/dd/year

SSN _____ - _____ - _____

Address:

_____ Apt # _____
 Street Address

_____ City _____ State _____ Zip Code _____

Contact Phone Numbers (in order of best number to call first):

1. (____) _____ - _____ Home ___ Cell ___ Work ___ Other _____

2. (____) _____ - _____ Home ___ Cell ___ Work ___ Other _____

3. (____) _____ - _____ Home ___ Cell ___ Work ___ Other _____

Do you work or go to school during the day? Yes _____ No _____

| Availability for Study Visits | Yes | No | Exceptions or Comments |
|-------------------------------|-----|----|------------------------|
| Anytime | | | |
| Weekdays - (8am - 9am) | | | |
| Weekdays - (9am - 5pm) | | | |
| Weekdays - (5pm - 7pm) | | | |
| Saturday | | | |
| Sunday | | | |

Gender: Male _____ Female _____

If female, are you pregnant or trying to become pregnant? Yes _____ No _____

If female, are you of child bearing potential? Yes _____ No _____

If "Yes" record method of contraception: _____

If "No" record why not of child-bearing potential _____

If Post-Menopausal, date of LMP _____



Race: Caucasian _____ Asian _____ American Indian or Alaska Native _____
 Black/African American _____ Native Hawaiian or Other Pacific Islander _____
 Other _____ Specify _____

Are you on any medications? Yes _____ No _____

If yes, please list:

| Name of Medication | Dosage | How often | How you take it | Reason you take this medication | Date started mm/dd/year |
|--------------------|--------|-----------|-----------------|---------------------------------|-------------------------|
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Surgical Procedures: Yes _____ No _____

If yes, please list:

| Surgery | Reason for Surgery | Date of Surgery mm/dd/year |
|---------|--------------------|----------------------------|
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Medical History

| System | Yes | No | If "Yes" Specify | Start Date mm/dd/yyyy | Stop Date or Ongoing |
|--|-----|----|------------------|--------------------------|-------------------------|
| Allergies | | | | | |
| General Body (i.e. obesity) | | | | | |
| Dermatologic (i.e. skin disorders) | | | | | |
| Immunologic (i.e. HIV, lupus, Graves disease) | | | | | |
| HEENT (i.e. vision, hearing, sinus disorders) | | | | | |
| Respiratory (i.e. asthma, COPD, bronchitis) | | | | | |
| Cardiovascular (i.e. blood pressure, cholesterol, heart disease) | | | | | |
| GI/Hepatic (i.e. hepatitis, GERD, ulcers, pancreatitis) | | | | | |
| Musculoskeletal (i.e. arthritis, back disorders, joint injuries) | | | | | |
| Neurologic (i.e. headaches, seizures, neuropathy) | | | | | |
| Genitourinary/ Gynecological (i.e. Pregnancies (list with dates), tubal ligation, UTI, STD) | | | | | |

| System | Yes | No | If "Yes" Specify | Start Date mm/dd/yyyy | Stop Date or Ongoing |
|---|-----|----|------------------|--------------------------|-------------------------|
| Hematologic (i.e. blood disorders, anemia, hemophilia) | | | | | |
| Endocrine (i.e. diabetes, thyroid disorder) | | | | | |
| Psychiatric (i.e. depression, bipolar) | | | | | |
| Other | | | | | |

Type of Study you are interested in: (eg. Acne, Cosmetic, Skin Cancer etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Comments:-

Thank you for your interest in participating in one of our clinical studies. We will contact you to determine if you are eligible for any of our upcoming studies.

Please fax (727-572-1331) this form back to Lynn Allen, RN, Clinical Study Coordinator

