PATIENT INITIALS

CEDAR CROSSE
research center

VOLUNTEER INFORMATION & MEDICAL HISTORY

PERSONAL INFORMATION

LAST NAME | FIRST NAME | MI | SEX (M F) | DATE OF BIRTH

ADDRESS | APT/SUITE/UNIT

CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

EMAIL | PREFERRED METHOD OF CONTACT (CELL PHONE WORK PHONE HOME PHONE EMAIL)

PHYSICIAN & PHARMACY

PRIMARY CARE PHYSICIAN | PRIMARY CARE PHONE

PHARMACY/LOCATION | PHARMACY PHONE

RACE & ETHNICITY

CAUCASIAN AFRICAN AMERICAN HISPANIC NATIVE AMERICAN ASIAN OTHER

RACE | ETHNICITY

REFERRAL

How did you hear about us? ☐ CRAIGSLIST ☐ TWITTER ☐ BILLBOARD ☐ FACEBOOK

☐ RED EYE/NEWSPAPER ☐ RADIO ☐ FRIEND: _____ ☐ OTHER: _____

MEDICAL HISTORY FORM CONT'D

EMERGENCY CONTACT (Please list at least 1 emergency contact that does not live in your home)

1

EMERGENCY CONTACT #1 NAME

EMERGENCY CONTACT #1 PHONE

EMERGENCY CONTACT #1 EMAIL

EMERGENCY CONTACT #1 RELATIONSHIP

2

EMERGENCY CONTACT #2 NAME

EMERGENCY CONTACT #2 PHONE

EMERGENCY CONTACT #2 EMAIL

EMERGENCY CONTACT #2 RELATIONSHIP

Please answer all of the following questions:

1. Smoking History

☐ Y ☐ N I have never smoked.

☐ Y ☐ N I am a current smoker.

DATE STARTED SMOKING

AMOUNT PER DAY

☐ Y ☐ N I am a previous smoker.

DATE STARTED SMOKING

DATE QUIT SMOKING

AMOUNT PER DAY

2. Alcohol History

Amount of alcohol is defined as 12oz regular or lite beer = 1 drink, 4oz wine = 1 drink, 1oz shot = 1 drink.

☐ Y ☐ N I have never consumed alcoholic beverages.

☐ Y ☐ N I do not consume alcoholic beverages.

☐ Y ☐ N I currently consume alcoholic beverages.

YEAR STARTED DRINKING

TYPE OF ALCOHOL

AMOUNT PER WEEK (AVERAGE)

3. Infectious Diseases

☐ Y ☐ N I have been diagnosed with Human Immunodeficiency Virus (HIV).

DIAGNOSIS DATE

MEDICAL HISTORY FORM CONT'D

4. Prescription Medication/Supplements

☐ Y ☐ N I am taking medication, including over-the-counter medication, on a regular basis.

MEDICATION	START DATE	STOP DATE	DOSE/UNITS	FREQUENCY	FORM OF MEDS	REASON	INITIAL & DATE

MEDICAL HISTORY FORM CONT'D

5. Medication Allergies

☐ Y ☐ N I am allergic to or intolerant of at least one medication.

MEDICATION	REACTION	DATE IDENTIFIED	REVIEWERS COMMENTS

6. Non-Medication Allergies

☐ Y ☐ N I have 'non-medication' allergies.

ENVIRONMENTAL/SEASONAL/ FOODS/ANIMALS	REACTION	DATE IDENTIFIED	REVIEWERS COMMENTS
1			
2			
3			

7. Hematology (Blood)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ANEMIA					
OTHER:					
OTHER:					
OTHER:					

PATIENT INITIALS

MEDICAL HISTORY FORM CONT'D

8. Blood Donation

☐ Y ☐ N I have donated blood in the past year.

DATE	REVIEWERS COMMENT

9. Plasma Donation

☐ Y ☐ N I have donated plasma in the past year.

DATE	REVIEWERS COMMENT

10. Surgeries

☐ Y ☐ N I have had surgery.

EVENT	DATE	REVIEWERS COMMENT

MEDICAL HISTORY FORM CONT'D

11. Dermatological (Skin)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ECZEMA (SEVERE DRY SKIN)					
OTHER:					
OTHER:					

12. Cardiovascular (Heart & Circulation)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
BLOOD CLOTS					
HIGH BLOOD PRESSURE (HYPERTENSION)					
HEART ATTACK (MI)					
CORONARY (HEART) ARTERY DISEASE					
CAROTID (NECK) ARTERY DISEASE					
CLAUDICATION					
ANGINA (CHEST PAIN)					
PALPITATION (FEELING HEART BEAT)					
CONGESTIVE HEART FAILURE (DILATED HEART)					
PERIPHERAL VASCULAR DISEASE (LEGS)					
EDEMA (SWELLING)					
HIGH CHOLESTEROL (HYPERCHOLESTEROLEMIA)					
OTHER:					

MEDICAL HISTORY FORM CONT'D

13. Musculoskeletal (Muscle & Bones)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
MUSCLE PAIN					
WEAKNESS					
BACK/NECK PAIN					
JOINT PAIN LOCATION:					
JOINT PAIN LOCATION:					
ARTHRITIS:					
BROKEN/FRACTURED BONES:					
OTHER:					
OTHER:					
OTHER:					

14. Gastrointestinal (Stomach & Intestines)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ESOPHAGEAL REFLUX/INDIGESTION (HEARTBURN)					
DIARRHEA					
CONSTIPATION					
STOMACH ULCER					
GALLBLADDER DISEASE					
DIVERTICULITIS/DIVERTICULOSIS					
PANCREATIC DISEASE					
OTHER:					

MEDICAL HISTORY FORM CONT'D

15. Endocrine (Metabolism)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
DIABETES: TYPE 1					
DIABETES: TYPE 2					
THYROID (HYPERTHYROIDISM)					
THYROID (HYPOTHYROIDISM)					
GOUT					
OBESITY					
OTHER:					

16. Neurological (Nerves)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
MIGRAINE HEADACHES					
STROKE (CVA)					
NEUROPATHY					
TIA (TRANSIENT ISCHEMIC ATTACK)					
EPILEPSY (SEIZURES)					
OTHER:					

17. Nose/Mouth/Throat

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
SINUS PROBLEMS					
OTHER:					

MEDICAL HISTORY FORM CONT'D

18. Ears

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
HEARING LOSS					
BALANCE PROBLEMS					
OTHER:					

19. Eyes

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
GLASSES/CONTACTS					
CATARACTS					
GLAUCOMA					
DIABETIC RETINOPATHY					
OTHER:					

20. Hepatic (Liver)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ELEVATED LIVER ENZYMES					
HEPATITIS (CHOOSE ONE: A B C)					
CIRRHOSIS					
FATTY LIVER					
OTHER:					

MEDICAL HISTORY FORM CONT'D

21. Pulmonary

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ASTHMA					
BRONCHITIS					
EMPHYSEMA					
PNEUMONIA					
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)					

22. Psychological

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ALCOHOLISM					
RECREATIONAL DRUG USE					
DEPRESSION					
ANXIETY/PANIC DISORDER					
EATING DISORDERS					
INSOMNIA					
OTHER:					

23. Cancer (All types including Blood & Skin cancers)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
LOCATION: *TYPE:*					
LOCATION: *TYPE:*					
LOCATION: *TYPE:*					

MEDICAL HISTORY FORM CONT'D

24. Renal (Kidney & Urinary)

Please ONLY check conditions that you have been diagnosed with by a physician.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
URINATION OR BLADDER PROBLEMS					
URINARY TRACT INFECTION					
KIDNEY INFECTION/STONES					
KIDNEY DISEASE					
OTHER:					

25. Male Reproductive

Please mark all that apply.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
ENLARGED PROSTATE					
HERNIA					
ERECTILE DISFUNCTION					
OTHER:					

26. Female Reproductive

Please mark all that apply.

DIAGNOSIS	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
CURRENTLY PREGNANT					
CURRENTLY BREASTFEEDING					
MENOPAUSAL					
HAD A HYSTERECTOMY (CHOOSE ONE: PARTIAL FULL)					
REGULAR PERIODS					
IRREGULAR PERIODS					

MEDICAL HISTORY FORM CONT'D

27. Birth Control

Please mark all that apply.

BIRTH CONTROL METHOD	YES	NO	START DATE	STOP DATE	REVIEWERS COMMENTS
TUBAL LIGATION					
BARRIER (DIAPHRAGM, CONDOM)					
SPERMICIDE					
PATCH (ORTHO-EVRA)					
NUVARING					
DEPO-VERA (INJECTION OF HORMONE)					
IUD					
ABSTINENCE					
VASECTOMY					
NO USE OF BIRTH CONTROL					
OTHER (RHYTHM METHOD)					
OTHER:					

The information that you have provided is strictly confidential and will only be used by Cedar Crosse Research Center. We will not disclose any information without your prior consent.

☐ Y ☐ N May we enter the information that you have provided into our secure electronic database?

☐ Y ☐ N May Cedar Crosse contact you in the future regarding possible research studies that you may qualify for?

☐ Y ☐ N I received a copy of the Cedar Crosse HIPPA policy regarding my personal health information.

☐ Y ☐ N I certify that all of the information stated within is true and correct to the best of my knowledge.

SIGNATURE OF VOLUNTEER _____ DATE _____

SIGNATURE OF REVIEWER _____ DATE _____

MEDICAL HISTORY FORM CONT'D

Updated Medical History

This section to be filled out by the reviewer.

DIAGNOSIS	START DATE	STOP DATE	REVIEWERS COMMENTS

PATIENT INITIALS

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the rights to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made my alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contact in the following manner (check all that apply)

CELL PHONE

- ☐ OK to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

HOME PHONE

- ☐ OK to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

WORK PHONE

- ☐ OK to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

WRITTEN COMMUNICATION

- ☐ OK to mail to my home.
- ☐ OK to mail to my work/office
- ☐ OK to fax to this number:

_____

- ☐ OK to email this email address:

_____

I authorize that my lab/test results may be released to the following person(s) indicated below.

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

PATIENT INITIALS

UPDATED MEDICAL HISTORY FORM

By signing below I have confirmed this information has been updated. Please sign at every new visit.

Update #1

SIGNATURE OF REVIEWER #1 — DATE

SIGNATURE OF REVIEWER #2 — DATE

SIGNATURE OF REVIEWER #3 — DATE

SIGNATURE OF VOLUNTEER — DATE

Update #2

SIGNATURE OF REVIEWER #1 — DATE

SIGNATURE OF REVIEWER #2 — DATE

SIGNATURE OF REVIEWER #3 — DATE

SIGNATURE OF VOLUNTEER — DATE

Update #3

SIGNATURE OF REVIEWER #1 — DATE

SIGNATURE OF REVIEWER #2 — DATE

SIGNATURE OF REVIEWER #3 — DATE

SIGNATURE OF VOLUNTEER — DATE

PATIENT INITIALS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge receipt of Cedar Crosse Research Centers Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practices may use and disclose my confidential health information.

I understand that Cedar Crosse Research Center has the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

LAST NAME | FIRST NAME | DATE OF BIRTH

SIGNATURE | DATE

If you are not the patient, please speicify your name and relationship to the patient.

LAST NAME | FIRST NAME | RELATIONSHIP

SIGNATURE | DATE