PATIENT DEMOGRAPHIC SHEET

Patient Name: _____ **Initials (first, middle, last):**_____ _____ _____

Date of Birth: _____/_____/_____ **Sex:** ❑ Male ❑ Female **Age:** _____ **years**

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Race:** ❑ Caucasian ❑ Asian ❑ African American/Black ❑ Native American ❑ Pacific Islander ❑ Other:_____

Address: _____
Street Address

_____
City State Zip Code

1) Home Phone #: _____ OK to leave message? ❑ Yes ❑ No

2) Mobile Phone #:_____ OK to leave message? ❑ Yes ❑ No

3) Work Phone #:_____ OK to leave message? ❑ Yes ❑ No

4) Other Phone #:_____ OK to leave message? ❑ Yes ❑ No

E-mail address: _____

STAFF USE ONLY

Confirmed working contact phone number?
❑ Yes ❑ No
❑ 1 ❑ 2 ❑ 3 ❑ 4

Initials/Date: _____

Emergency Contact

Name: _____ **Relationship:** _____ **Phone #** _____

How did you hear about us?

❑ Advertisement, specify: _____ ❑ Friend/family, name: _____

❑ Website/Web Search: _____ ❑ Healthcare provider, name: _____

❑ Outreach worker, name: _____ ❑ Event, specify: _____

Do you have a primary care physician? ❑ Yes ❑ No

Physician or clinic name: _____

Contact information: _____

Terms of Agreement

eStudySite is operated for the purpose of conducting clinical studies of experimental treatments (clinical trials). All of the patients who are evaluated at eStudySite are seen in association with their participation, or potential participation, in clinical trials. The medical evaluation performed at eStudySite is limited and should not be considered a substitute for a thorough evaluation, ongoing care, or follow-up by a personal physician. Also, because eStudySite does not provide routine outpatient care, individuals who participate in a study should continue under the care of their personal physicians during and after their involvement in a study.

While eStudySite sometimes provides outpatient medical care to individuals who have participated in experimental studies, and may provide such care free of charge, eStudySite does not assume financial responsibility for such patient's ongoing inpatient or outpatient medical care, will not pay for any outpatient care received from healthcare providers other than eStudySite, and will not pay for hospitalization which is not related to the patient's participation in a clinical trial.

I understand and affirm that neither eStudySite nor the physicians or other medical professionals at eStudySite have assumed any responsibility, financial or otherwise, for my medical care.

I understand that any additional care, including diagnostic studies or treatment which I may receive at the clinic, is provided voluntarily by eStudySite and does not suggest or establish any agreement by eStudySite to assume financial responsibility for my ongoing medical care needs.

I, **_____,** hereby give my consent to be interviewed and tested by the medical professionals at eStudySite. Information will be utilized to determine my eligibility for participating in a clinical research study. I understand eligibility is determined solely by eStudySite personnel. My agreement to be interviewed does not mean that I will be accepted into a study.

I understand I will be asked about my medical, social, and psychiatric history. As a part of the standard health screening process, I may also undergo physical testing (for example, a screening limited to physical exam, vital signs, EKG, and/or routine blood and urine testing, etc.). Based upon these results, if it appears that I may be a good candidate, I understand that I will receive a detailed consent, designed specifically for the appropriate study.

_____ _____

Signature of Person Completing Form **Date**

This form was completed by: ❑ **Patient** ❑ **Legal Guardian:** _____

Print Name

❑ **Other (specify):**_____

PATIENT MEDICAL HISTORY

Patient Name:_____ **Initials:** _____- _____ - _____ **Date of Visit:**_____

Prior Study Participation

Have you ever participated in any other research study? ❑ Yes ❑ No

If yes, for what condition?_____

Did you receive medication in the study? ❑ Yes ❑ No

Start Date:____/____/____ Stop Date:____/____/____ (approximate)

SOCIAL HISTORY

Have you ever smoked tobacco products? ❑ Yes ❑ No

If yes, start date:_____ Number of packs per day ❑ 1/2 pack ❑ 1 pack ❑ 1.5 packs ❑ 2 packs or more

End date if applicable:_____

Have you ever drank alcoholic beverages? ❑ Yes ❑ No

If yes, start date:_____ How many drinks per day?_____

End date if applicable:_____ How many drinks per week?_____

Have you ever used illicit drugs? ❑ *Yes ❑ No

* If yes, please check all that apply. Include start and stop dates:

	Start Date	**Stop Date**
❑ Marijuana	_____	_____
❑ Methamphetamine	_____	_____
❑ Cocaine	_____	_____
❑ Heroin	_____	_____
❑ Other:_____	_____	_____

Employment status:

❑ Employed ❑ Unemployed ❑ Retired

Initials: _____- _____ - _____

Do you currently have or have you ever had any of the following diagnosed by a healthcare provider? Please circle NO or Yes				*Staff Use Only-*			
Item #	**ALLERGIES** *Specify allergen and reaction for all.*			**Start date mm/dd/yyyy**	**Stop date or "cont." if ongoing mm/dd/yyyy**	**Con med taken? (List on Con Med Log)**	**Notes During Interview- Clarify all "yes" answers & other relevant information**
1	Drug Allergies:(Example: Penicillin - hives) Specify:_____	N	**Y**			Yes No	
2	Environmental Allergies:(Dust, Mold, Pollen, Grass)	N	**Y**			Yes No	
3	Food Allergies:(Example: Nuts-hives) Specify:_____	N	**Y**			Yes No	
4	Animal Allergies:(Example: Cat-hives) Specify:_____	N	**Y**			Yes No	
5	Other allergy problems (specify):					Yes No	
	LUNGS / PULMONARY						
6	Asthma	N	**Y**			Yes No	
7	Emphysema / COPD	N	**Y**			Yes No	
8	Pneumonia	N	**Y**			Yes No	
9	Tuberculosis	N	**Y**			Yes No	
10	Pulmonary Embolism	N	**Y**			Yes No	
11	Other pulmonary problems (specify):					Yes No	
	EYES, EARS, NOSE, THROAT						
12	Hearing Loss: ❑Right Ear ❑Left Ear	N	**Y**			Yes No	
13	Cataracts: ❑ Right Eye ❑ Left Eye	N	**Y**			Yes No	
14	Glaucoma	N	**Y**			Yes No	
15	Use of prescription lenses	N	**Y**			Yes No	
16	Diabetic Retinopathy or Retina problems	N	**Y**			Yes No	
17	Other eye, ear, nose, throat problems (specify):					Yes No	
	ENDOCRINE						
18	Diabetes: ❑ Type I ❑ Type II	N	**Y**			Yes No	
19	Hypothyroidism	N	**Y**			Yes No	
20	Hyperthyroidism	N	**Y**			Yes No	
21	Obesity/Weight problems	N	**Y**			Yes No	
22	Adrenal problems (Addison's, Cushing's disease)	N	**Y**			Yes No	
23	Other endocrine problems (specify):	N	**Y**			Yes No	

Initials: _____- _____ - _____

	SKIN / DERMATOLOGICAL			Start date mm/dd/yyyy	Stop date or "cont." if ongoing mm/dd/yyyy	Con med taken? (List on Con Med Log)	Notes During Interview- Clarify all "yes" answers & other relevant information
24	Eczema / Atopic Dermatitis	N	**Y**			Yes No	
25	Hives	N	**Y**			Yes No	
26	Skin infection	N	**Y**			Yes No	
27	MRSA	N	**Y**			Yes No	
28	Vitiligo	N	**Y**			Yes No	
29	Psoriasis	N	**Y**			Yes No	
30	Acne	N	**Y**			Yes No	
31	Rosacea	N	**Y**			Yes No	
32	Actinic Keratosis	N	**Y**			Yes No	
33	Other skin problems (specify):					Yes No	
	HEART / CARDIOVASCULAR						
34	Hypertension	N	**Y**			Yes No	
35	High Cholesterol	N	**Y**			Yes No	
36	Heart Attack / Myocardial Infarction	N	**Y**			Yes No	
37	Heart Murmur	N	**Y**			Yes No	
38	Congestive Heart Failure	N	**Y**			Yes No	
39	Atrial Fibrillation	N	**Y**			Yes No	
40	Abnormal Heart Rate (SVT, Tachycardia, Bradycardia)	N	**Y**			Yes No	
41	Other heart problems (specify):					Yes No	
	DIGESTIVE / GASTROINTESTINAL						
42	Irritable Bowel Syndrome	N	**Y**			Yes No	
43	Ulcer	N	**Y**			Yes No	
44	Pancreatitis	N	**Y**			Yes No	
45	Gastroesophageal Reflux (GERD)	N	**Y**			Yes No	
46	Gall Stones / Gallbladder disease	N	**Y**			Yes No	
47	Constipation	N	**Y**			Yes No	
48	Fatty Liver (NASH Steatohepatitis)	N	**Y**			Yes No	
49	Clostridium Difficile Infection (C.diff)	N	**Y**			Yes No	
50	Other stomach or abdominal problems(specify):					Yes No	

Initials: _____- _____ - _____

	GENITOURINARY / RENAL			Start date mm/dd/yyyy	Stop date or "cont." if ongoing mm/dd/yyyy	Con med taken? (List on Con Med Log)	Notes During Interview- Clarify all "yes" answers & other relevant information
51	Frequent Urinary Tract Infections	N	**Y**			Yes No	
52	Kidney Infections	N	**Y**			Yes No	
53	Kidney Stones	N	**Y**			Yes No	
54	Kidney Failure	N	**Y**			Yes No	
55	Other genital or urinary problems (specify):					Yes No	
	BLOOD / HEMATOLOGICAL						
56	Anemia	N	**Y**			Yes No	
57	Low Platelets	N	**Y**			Yes No	
58	Deep Venous Thrombosis	N	**Y**			Yes No	
59	Abnormal Bleeding	N	**Y**			Yes No	
60	Other blood problems (specify):					Yes No	
	MUSCULOSKELETAL						
61	Osteoarthritis (general arthritis)	N	**Y**			Yes No	
62	Rheumatoid Arthritis	N	**Y**			Yes No	
63	Osteoporosis	N	**Y**			Yes No	
64	Fibromyalgia	N	**Y**			Yes No	
65	Chronic back, neck or spine pain	N	**Y**			Yes No	
66	Other muscle, bone, or joint problems (specify):					Yes No	
	NEUROLOGICAL						
67	Migraine Headaches	N	**Y**			Yes No	
68	Non-migraine Headaches	N	**Y**			Yes No	
69	Seizures	N	**Y**			Yes No	
70	Stroke / TIA	N	**Y**			Yes No	
71	Multiple Sclerosis	N	**Y**			Yes No	
72	Other (specify):					Yes No	
	PSYCHOLOGICAL						
73	Insomnia	N	**Y**			Yes No	
74	Depression	N	**Y**			Yes No	
75	Anxiety	N	**Y**			Yes No	
76	Bipolar Disorder	N	**Y**			Yes No	
77	Schizophrenia	N	**Y**			Yes No	
78	Other (specify):					Yes No	

Initials: _____- _____ - _____

	INFECTIOUS DISEASE			Start date mm/dd/yyyy	Stop date or "cont." if ongoing mm/dd/yyyy	Con med taken? (List on Con Med Log)	Notes During Interview- Clarify all "yes" answers & other relevant information
79	Hepatitis Type : ❑ A ❑ B ❑ C	N	**Y**			Yes No	
80	HIV / AIDS	N	**Y**			Yes No	
81	Sexually Transmitted Infection	N	**Y**			Yes No	
82	Other infectious disease (specify):					Yes No	
	OTHER HISTORY						
83	Cancer / Malignancies	N	**Y**			Yes No	
84	Surgical / Non-Surgical Procedures	N	**Y**	Complete Surgical - Procedure Log			
85	Hospitalizations	N	**Y**	Complete Hosp.-Significant Family History Log			
86	Other problems (specify):					Yes No	
	MALES ONLY						
87	Vasectomy	N	**Y**			Yes No	
88	Benign Prostatic Hypertrophy (BPH)	N	**Y**			Yes No	
89	Prostate Problems	N	**Y**			Yes No	
90	Other problems (specify):					Yes No	
	FEMALES ONLY						
91	Uterine Fibroids	N	**Y**			Yes No	
92	Currently pregnant or breastfeeding	N	**Y**			Yes No	
93	Planning to become pregnant within the next six months?	N	**Y**			Yes No	
94	Tubal Ligation	N	**Y**			Yes No	
95	Hysterectomy	N	**Y**			Yes No	
96	Menopause	N	**Y**			Yes No	
97	Last Menstrual Period:_____					Yes No	
98	Are you using birth control?	N	**Y**			Yes No	

Completed by: ❑ **Patient** ❑ **Legal Guardian** ❑ **Other,**_____

Subject / LAR Signature:_____ **Date:**_____

	OTHER MEDICAL CONDITIONS			
99				Yes No
100				Yes No
101				Yes No

Staff Interviewer: ❑ Investigator ❑ CRC ❑ RN

CRC / RN Printed Name:_____Signature:_____ Date:_____

I have reviewed the medical history.

Investigator Printed Name:_____Signature:_____ Date:_____