

**Complete information is required for study entry and is updated with each new study*

First Name: _____ **Middle Initial:** _____ **Last Name:** _____
(Full Legal Name is required)

Date of Birth (dd/mmm/yyyy): _____ **Age:** _____

Gender: Male: Female:

Race: American Indian: Asian: Pacific Islander:

Caucasian/White: Black: Other: _____

Ethnicity: Hispanic or Latino: Not Hispanic or Latino:

Contact Information:

Address 1: _____

Phone Number(s): _____

Apt #: _____

*Cell Number: _____

City / State / Zip Code: _____

*Parent or Guardian Cell: _____

*E-Mail: _____

Home Number: _____

I agree to receive/Opt-in for the following types of text messages and email correspondence from MOORE Clinical Research, Inc. (please check):

Appointment Reminders/Confirmations Marketing for Future Studies Payment Status on Debit Cards

By my signature below, I certify that the information I have provided on this form is both true and accurate to the best of my knowledge.

Signature of Patient or Parent/Guardian: _____ Date: _____

**Parent/Guardian phone numbers and signatures are required when the patient is 17 years of age and younger*

****For Research Staff Use Only:**

This information has been reviewed and updated in the CTMS. Initials & Date: _____
(Scan and Save to Subject Documents then File in Source binder)

Medical History (please include start dates):

Cardiovascular

- Angina _____
- Arrhythmia _____
- Blood Clots _____
- Congestive Heart Failure _____
- Coronary Heart Disease _____
- High Cholesterol _____
- High Triglycerides _____
- High Blood Pressure _____
- Heart Attack _____
- Stroke _____

Ears/Eyes/Nose/Throat

- Hearing loss _____
- Tinnitus _____
- Vertigo _____
- Cataracts _____
- Glasses/Contacts _____
- Diabetic Retinopathy _____
- Glaucoma _____
- Macular Degeneration _____
- Sinusitis _____

Musculoskeletal

- Back Pain _____
- Bone Fracture _____
- Chronic Pain _____
- Fibromyalgia _____
- Gout _____
- Osteoarthritis _____
- Osteoporosis _____
- Rheumatoid Arthritis _____

Pulmonary

- Asthma _____
- Bronchitis _____
- COPD _____
- Emphysema _____
- Pneumonia _____
- Sleep Apnea _____
- Tuberculosis _____

Dermatology

- Acne _____
- Eczema _____
- Psoriasis _____
- Hives _____
- Rosacea _____
- Actinic Keratosis _____
- Athlete's Foot _____
- Toenail Fungus _____

Gastrointestinal

- Crohn's Disease _____
- Diverticulitis _____
- Esophageal Reflux _____
- Irritable Bowel Syndrome _____
- Ulcer _____
- Ulcerative Colitis _____

Immunologic/Auto Immune/

Infectious Disease

- AIDS _____
- Lupus _____
- HIV Positive _____
- MRSA _____
- Staph Infection _____

Endocrine

- Diabetes _____
- Goiter _____
- Hyperthyroid/Hypothyroid _____
- Hypoglycemia _____
- Obesity _____

Neurological/Psych

- Depression _____
- Anxiety _____
- Seizures _____
- Headaches/Migraines _____
- ADHD _____

Genitourinary

- Kidney Infection/Disease _____
- Incontinence _____
- UTI _____
- Menstrual Cramps _____

Hematologic

- Bleeding disorder _____
- Anemia _____
- Blood Cancer _____

Hepatic

- Cirrhosis _____
- Fatty Liver _____
- Hepatitis A, B or C _____

Female Method of Contraception

Type/Start Date _____

Menopause

Start Date _____

Cancer

Location and Year _____

Allergies (medications, seasonal, animal; please include a start date):

Please list all medications and supplements taken, including over the counter products (include dosages and start date):

Please list all previous surgeries, including the dates:
