

*\*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:

\_\_\_\_\_  
\_\_\_\_\_