MOORE CLINICAL RESEARCH, INC.

Patient Contact & Demographic Information

**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/mm/yyyy): _____ **Age**: _____

Gender: Male: ☐ Female: ☐ **Preferred Language:** _____

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. I have also read the 'Important Information to Our Patients' document.

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)

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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:

_____
_____