MOORE
CLINICAL RESEARCH, INC.

Patient Contact & Demographic Information

Returning Patient ☐ New Patient ☐

If New Patient, how did you hear about us? ________________ Did a family member or friend refer you?
If so, please provide their contact information (name and phone number): ____

First Name: ________________________ **Middle Initial**: _______ **Last Name**: ___________________________
(Your Full Legal Name is required)

Date of Birth (dd/mm/yyyy): _______________________ **Age**: _______________

Sex at Birth: Male: ☐ Female: ☐ **Preferred Language:** ______________________

Race: American Indian: ☐ Asian: ☐ Pacific Islander: ☐

Caucasian/White: ☐ Black: ☐ Other: _______________________

Ethnicity: Hispanic or Latino: ☐ Not Hispanic or Latino: ☐

Preferred Method of Contact: ☐ **Phone Call** ☐ **Text** ☐ **Email**

Address 1: ____ Phone Number(s):

Apt #: ____ *Cell Number: ____________________________

City / State / Zip Code: _________________________________ *Parent or Guardian Cell: ___________________

*E-Mail: ____ ***(*Parent/Guardian cell is required for all minors)***

*Emergency contact: Name: _____________________ Phone: ___________________ Relationship: _____________

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)

MOORE CLINICAL RESEARCH, INC.

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:

____

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