MALE AT BIRTH ONLY - PLEASE COMPLETE

YOUR BIRTH CONTROL (PLEASE CHECK ALL THAT APPLY)

☐ ABSTINENCE/NOT SEXUALLY ACTIVE ☐ CONDOM ☐ SPERMICIDE ☐ VASECTOMY - DATE OF SURGERY ____/____/____
☐ OTHER, SPECIFY: _____ ↘ CONFIRMATION OF SUCCESS (6-12 WEEKS) POST-OP? ☐YES ☐NO

YOUR PARTNER'S BIRTH CONTROL (PLEASE CHECK ALL THAT APPLY)

☐ BIRTH CONTROL PILL ☐ DIAPHRAGM/CERVICAL CAP ☐ IUD ☐ TUBAL LIGATION - DATE OF SURGERY ____/____/____
☐ HYSTERECTOMY - DATE OF SURGERY ____/____/____ ☐ POSTMENOPAUSAL - DATE ____/____/____ ☐ OTHER, SPECIFY: _____

- OR -

FEMALE AT BIRTH ONLY - PLEASE COMPLETE

MENSTRUAL STATUS

☐ PRE-MENSTRUAL (NEVER MENSTRUATED)
☐ MENSTRUATING
☐ POST-MENOPAUSAL
↘ DATE OF LAST MENSTRUAL CYCLE ____/____/____
☐ HYSTERECTOMY - DATE OF PROCEDURE ____/____/____

YOUR BIRTH CONTROL (PLEASE CHECK ALL THAT APPLY)

☐ ABSTINENCE/NOT SEXUALLY ACTIVE
☐ DIAPHRAGM/CERVICAL CAP
☐ INJECTABLE CONTRACEPTIVE - START DATE: ____/____/____
☐ IMPLANT - NAME: _____ START DATE ____/____/____
☐ BIRTH CONTROL PILLS - NAME: _____ START DATE ____/____/____
☐ IUD - PLACEMENT DATE ____/____/____
☐ TUBAL LIGATION - DATE OF PROCEDURE ____/____/____
☐ OTHER, SPECIFY: _____

YOUR PARTNER'S BIRTH CONTROL (PLEASE CHECK ALL THAT APPLY)

☐ CONDOM ☐ SPERMICIDE ☐ VASECTOMY - DATE OF SURGERY ____/____/____ ☐ OTHER, SPECIFY: _____
↘ CONFIRMATION OF SUCCESS (6-12 WEEKS) POST-SURGERY? ☐ YES ☐ NO

DERMATOLOGICAL HISTORY

HAVE YOU BEEN FORMALLY DIAGNOSED WITH ANY DERMATOLOGICAL CONDITIONS? EXAMPLES: ACNE, ALOPECIA, ATOPIC DERMATITIS (ECZEMA), LUPUS, ROSACEA, PSORIASIS, SKIN CANCER (BASAL CELL, SQUAMOUS CELL), VITILIGO, ETC.?

CONDITION	ONSET DATE	END DATE	CURRENTLY TAKING MEDICATION(S) FOR THE CONDITION?	IF YOU HAVE TREATED YOUR CONDITION IN THE PAST, SPECIFY TREATMENT	FOR OFFICE USE ONLY
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS
		☐ ONGOING	☐ YES ☐ NO		☐ NCS

SURGERY HISTORY - PLEASE COMPLETE FOR ANY SURGERIES ☐ **NONE**

SURGERY	INDICATION (REASON)	DATE	FOR OFFICE USE ONLY
			☐ NCS
			☐ NCS
			☐ NCS
			☐ NCS
			☐ NCS

Reveiwed By: _____
Date: _____

GENERAL HEALTH HISTORY

BODY REGION	DIAGNOSIS	ONSET DATE	END DATE (IF APPLICABLE)	CURRENTLY TAKING MEDICATIONS FOR THESE CONDITIONS?	FOR OFFICE USE ONLY
HEAD, EYES, EARS, NOSE, THROAT, PULMONARY (Allergies (Seasonal,food, medications), Cataracts, Glaucoma, Asthma, COPD, ephysema, other)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	☐ YES ☐ NO	☐ NCS
CARDIO-VASCULAR (Arrhythmia, Congestive Heart Failure, Debrillator/ Pacemaker, Heart Attack, Heart Valve Disease or replacement, High Blood Pressure, High Cholesterol, Other)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	☐ YES ☐ NO	☐ NCS
LIVER AND GASTRO-INTESTINAL (Cirrhosis, Crohn's, Gall stones, GERD/Acid Reflux, Irritable Bowel Syndrome, Peptic Ulcers, Ulcerative Colitis, Other)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	☐ YES ☐ NO	☐ NCS
RENAL OR KIDNEY (englarded prostate/BPH, Dialysis, Kidney stones, renal insufficiency, other)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____ 6. ____/____/____ 7. ____/____/____ 8. ____/____/____ 9. ____/____/____ 10. ____/____/____	☐ YES ☐ NO	☐ NCS

Check here if you have NONE of the General Medical History listed on this page ☐ **NONE**

Reveiwed By: _____
Date: _____

GENERAL HEALTH HISTORY - CONTINUED					
ENDOCRINE/ IMMUNE (Type 1 Diabetes, Type 2 Diabetes, Hypothyroid, Hyperthyroid, Graves disease, Hashimoto thyroiditis, Multiple sclerosis, Sjogren Syndrome, Systemic Lupus)	**1.** _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____ **6.** _____ **7.** _____ **8.** _____ **9.** _____ **10.** _____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	☐ YES ☐ NO	☐ NCS
NEUROLOGIC/ PSYCHIATRIC (Anxiety, Chemical dependence/addiction, depression, headaches, insomnia, migraines, seizures, epilelpsy, stroke, suicide attempt, other)	**1.** _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____ **6.** _____ **7.** _____ **8.** _____ **9.** _____ **10.** _____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	☐ YES ☐ NO	☐ NCS
MUSCULO-SKELETAL (Osteo Arthritis, Rheumatoid Arthritis, Psoriatic Arthritis, artificial joint, Gout, Osteoporosis other)	**1.** _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____ **6.** _____ **7.** _____ **8.** _____ **9.** _____ **10.** _____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	☐ YES ☐ NO	☐ NCS
INFECTIONS/ GENERAL (Genital Herpes, Herpes Simplex (Cold sores/Fever blisters), Herpes Zoster (shingles), Hepatitis A, B OR C, HIV/AIDS, Tuberculosis, other)	**1.** _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____ **6.** _____ **7.** _____ **8.** _____ **9.** _____ **10.** _____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	**1.** _____/_____/_____ **2.** _____/_____/_____ **3.** _____/_____/_____ **4.** _____/_____/_____ **5.** _____/_____/_____ **6.** _____/_____/_____ **7.** _____/_____/_____ **8.** _____/_____/_____ **9.** _____/_____/_____ **10.** _____/_____/_____	☐ YES ☐ NO	☐ NCS

Check here if you have NONE of the General Medical History listed on this page ☐ NONE

Reveiwed By: _____
Date: _____

ALCOHOL, TOBACCO AND RECREATIONAL DRUG HISTORY

Check here if you have NONE of the Alcohol, Tobacco or Drug History listed below ☐ **NONE**

SUBSTANCE	DATE OF FIRST USE	DATE OF LAST USE	AMOUNT USED	FOR OFFICE USE ONLY
ALCOHOL - BEER		☐ ONGOING	NUMBER OF 12oz. DRINKS: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS
ALCOHOL - LIQUOR		☐ ONGOING	NUMBER OF 2oz. DRINKS: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS
ALCOHOL - WINE		☐ ONGOING	NUMBER OF 5oz. DRINKS: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS
TOBACCO - CIGARETTES		☐ ONGOING	NUMBER OF CIGARETTES PER DAY: _____ **OR** NUMBER OF PACKS PER DAY: _____	☐ NCS
TOBACCO - CIGARS		☐ ONGOING	NUMBER OF CIGARS: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS
TOBACCO - E-CIGARETTE		☐ ONGOING	NUMBER OF PUFFS: _____ ☐PER HOUR ☐PER DAY ☐PER WEEK ☐PER MONTH	☐ NCS
TOBACCO - SMOKELESS		☐ ONGOING	NUMBER OF CANS: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS
OTHER RECREATIONAL DRUGS, SPECIFY: _____		☐ ONGOING	AMOUNT: _____ ☐PER DAY ☐PER WEEK ☐PER MONTH ☐PER YEAR	☐ NCS

MEDICATION LIST - PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS INCLUDING HERBAL SUPPLEMENTS

Check here if you are taking NO MEDICATIONS, VITAMINS OR SUPPLEMENTS ☐ **NONE**

MEDICATION, VITAMIN, SUPPLEMENT OR RECENT VACCINE NAME	DOSE AND FREQUENCY (HOW OFTEN)	ROUTE (EX. ORAL, TOPICAL, ETC.)	DATE OF FIRST USE	DATE OF LAST USE (LEAVE BLANK IF ONGOING)	REASON FOR TAKING MEDICATION	FOR OFFICE USE ONLY	

PHYSICIAN CONTACT

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ **YES** ☐ **NO**

***IF YES, PLEASE PROVIDE THE CONTACT INFORMATION BELOW.**

PHYSICIAN'S NAME: **PHONE NUMBER:**

ADDRESS:

MAY WE CONTACT YOUR PRIMARY CARE PHYSICIAN? ☐ **YES** ☐ **NO**

Reveiwed By: _____
Date: _____

CONSENTS FOR PARENT(S)/LEGAL GUARDIAN(S) OF MINOR PATIENTS ☐ N/A
FOR ALL MINOR PATIENTS:
DO YOU CONSENT TO ALLOWING OTHER ADULTS (OVER THE AGE OF 18) TO BRING YOUR CHILD TO APPOINTMENTS TO CONDUCT PROTOCOL-SPECIFIED PROCEDURES, FOLLOWING THE SCREENING AND ENROLLMENT VISITS, AND TO VISITS WHERE RE-CONSENT IS NOT REQUIRED?
☐ YES ☐ NO PARENT/LEGAL GUARDIAN INITIALS: _____
FOR PATIENTS WHO ARE ≥ 16 YEARS OF AGE: ☐ N/A
DO YOU CONSENT TO ALLOWING YOUR CHILD, WHO IS ≥ 16 YEARS OF AGE, TO ATTEND APPOINTMENTS ALONE TO CONDUCT PROTOCOL-SPECIFIED PROCEDURES, FOLLOWING THE SCREENING AND ENROLLMENT VISITS, AND TO VISITS WHERE RE-CONSENT IS NOT REQUIRED?
☐ YES ☐ NO PARENT/LEGAL GUARDIAN INITIALS: _____

OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE UNLESS INSTRUCTED BY STAFF

MINOR PATIENT ☐ N/A
WAS ADEQUATE DOCUMENTATION PROVIDED TO VERIFY PARENTAGE/LEGAL GUARDIANSHIP? ☐ YES ☐ NO
IF YES, WHICH COMBINATION OF DOCUMENTATTION WAS PROVIDED TO SITE STAFF?
☐ CHILD'S BIRTH CERTIFICATE/PARENT ID ☐ ADOPTION DECREE/PARENT ID ☐ GUARDIANSHIP DECREE/GUARDIAN ID

STAFF/PATIENT REVIEW SIGNATURE PAGE

ONCE INFORMAITON ABOVE HAS BEEN REVIEWED WITH THE PATIENT (OR PARENT/LEGAL GUARDIAN), STUDY COORDINATOR AND INVESTIGATOR, PLEASE SIGN BELOW. ADDITIONAL SIGNATURES TO BE USED FOR DOCUMENTATION AND REVIEW OF UNREPORTED HISTORY DISCLOSED FOLLOWING THE SCREENING VISIT OR RE-REVIEW FOLLOWING TRANSFER TO A NEW STUDY.

Patient Signature (or parent/legal guardian)	Study Coordinator Signature	Investigator Signature
X_____ Date _____	X_____ Date _____	X_____ Date _____
Patient Signature (or parent/legal guardian)	Study Coordinator Signature	Investigator Signature
X_____ Date _____	X_____ Date _____	X_____ Date _____
Patient Signature (or parent/legal guardian)	Study Coordinator Signature	Investigator Signature
X_____ Date _____	X_____ Date _____	X_____ Date _____
Patient Signature (or parent/legal guardian)	Study Coordinator Signature	Investigator Signature
X_____ Date _____	X_____ Date _____	X_____ Date _____
Patient Signature (or parent/legal guardian)	Study Coordinator Signature	Investigator Signature
X_____ Date _____	X_____ Date _____	X_____ Date _____

**** This is for Dawes Fretzin Clinical Research Group, LLC informational purposes only. Information is self-reported by the patient (or parent/legal guardian) and may not be all inclusive. ****