

Dawes Fretzin Clinical Research Group, LLC
7910 North Shadeland Avenue
Indianapolis, IN 46250

Patient Name: _____ Date of Birth: _____ Date: _____

SELF REPORTED PERSONAL MEDICAL HISTORY

For DFCRG informational purposes only. Information is self-reported and not all inclusive

PLEASE LIST ALL MEDICAL CONDITIONS INCLUDING DATE OF DIAGNOSIS:

Yes	No		<u>Date</u>	Yes	No		<u>Date</u>
<u>Cardiovascular</u>				<u>Eye</u>			
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	_____	<u>Neurologic/Psychiatric</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Rhythm	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve	_____	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	_____
<input type="checkbox"/>	<input type="checkbox"/>	Disease/Replacement	_____	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	_____
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator/Pacemaker	_____	<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	_____
<u>Pulmonary</u>				<u>Endocrine</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I	_____
<input type="checkbox"/>	<input type="checkbox"/>	COPD	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type II	_____
<u>Renal/Kidney</u>				<u>Musculoskeletal</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Renal Insufficiency	_____	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	_____	<input type="checkbox"/>	<input type="checkbox"/>	Psoriatic Arthritis	_____
<u>Liver/Gastrointestinal</u>				<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	_____	<u>General</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gall Stones	_____	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	_____
<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gout	_____
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel syndrome	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	GERD	_____	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____	
<u>Skin</u>							
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Acne	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Atopic Dermatitis/Eczema	_____				
<u>Females</u>				<u>Males</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Surgically Sterile	_____	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control	_____	<input type="checkbox"/>	<input type="checkbox"/>	Partner post menopause	_____
<input type="checkbox"/>	<input type="checkbox"/>	Postmenopausal	_____	<input type="checkbox"/>	<input type="checkbox"/>	Partner Surgically sterile	_____
		Last Menstrual Cycle	_____				

Contraception Method: _____

Alcohol Use: Yes No If Yes: How many drinks _____ Per Week / Month/Year How Long: _____ years
 What type: Beer Wine Liquor

Tobacco Use: Yes No If Yes: How many _____ Per Day / Week How Long: _____ years
 What type: Cigarettes Cigars Pipe

Any other medical history not previously addressed: _____

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PREVIOUS SURGERIES

Name of Surgery:	Date:	Reason:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

MEDICATIONS (Including all over the counter medications, vitamins and supplements)

Medication Name:	Dosage:	Reason taken:	Start Date:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

ALLERGIES TO MEDICATIONS

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

PRIMARY CARE PHYSICIAN

May we contact your primary care physician? Yes No

Physician's Name: _____ Phone Number: _____

Address: _____

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: _____

Completed By – Patient Signature: _____ Date: _____

Reviewed By – Study Coordinator Signature: _____ Date: _____