THE
INDIANA CLINICAL
TRIALS CENTER

INTAKE FORM

PLEASE READ BEFORE COMPLETING INTAKE FORM

Dear Study Volunteer:

Clinical research cannot happen without volunteers like you!

Clinical research involves studying new investigational medications and devices in order to have safe and effective medical options for all of us in the future.

In order to decide if you are the right candidate to participate in a study and to understand how you respond during the study, we need to ask you a lot of very detailed questions about your current and past medical history.

Please answer the following questions about your health as completely as you can. If there are things you do not understand, a staff member will be reviewing your form with you during your appointment and will help you by answering any questions you may have at that time.

If you received this Confidential Medical Intake Form in the mail, please complete it and bring it with you to your office visit. ***You will sign and date your Medical Intake Form during your office visit.*** Additionally, bring with you any prescription or non-prescription medications you may be taking.

Thanks so much for your help!

Your ICTC Team

THE
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TRIALS CENTER

COMPLETED BY OFFICE STAFF

Subject Initials: _____ Subject Number: _____

Protocol #: _____

CONFIDENTIAL MEDICAL INTAKE FORM

FIRST NAME: _____ **MIDDLE INITIAL:** _____ **LAST NAME:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

CELLPHONE #: _____ **WORK #:** _____ **HOME #:** _____

EMAIL: _____

DATE OF BIRTH: _____ **GENDER AT BIRTH:** ☐ Male ☐ Female

SOCIAL SECURITY # *(Required)*: _____ **ETHNICITY:** ☐ Hispanic ☐ Non-Hispanic

RACE: ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian

☐ Caucasian/White ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

IF PATIENT IS UNDER 12 YEARS OLD, PLEASE PROVIDE LEGAL GUARDIAN'S INFORMATION:

NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

IN CASE OF EMERGENCY NOTIFY: _____

RELATIONSHIP: _____ **PHONE:** _____

PRIMARY CARE PHYSICIAN INFORMATION ☐ *NONE*

DOCTOR: _____ **PHONE:** _____

PRACTICE: _____ **FAX:** _____

HOW DID YOU HEAR ABOUT US FOR THIS STUDY OPPORTUNITY?

☐ Past Trial Participant ☐ Website ☐ Email ☐ TV Ad ☐ Sponsor Marketing

☐ Radio Ad ☐ Word of Mouth *(Family/Friend)* ☐ Social Media *(Facebook, Instagram, Twitter)*

☐ Referred from Dr. Guenthner/DCI

☐ Another Dr.'s Office: Who? _____

☐ Other (Please specify): _____

INSTRUCTIONS:

1. **CHECK Diseases or Conditions you now have or have been diagnosed with in the past.**
2. **If none apply, please check "NONE OF THE ABOVE".**
3. **Please add start and stop dates (if applicable). If exact dates are not known, estimate approximate year. If ongoing, add "Ongoing" for the stop date.**
4. **Please use "other" under each body system to add any information you feel is important.**

EYES/EARS/NOSE/THROAT — START DATE — STOP DATE

- ☐ GLAUCOMA ☐ *Left* ☐ *Right* ☐ *Both* _____ _____
- ☐ CATARACTS ☐ *Left* ☐ *Right* ☐ *Both* _____ _____
- ☐ HEARING LOSS ☐ *Left* ☐ *Right* ☐ *Both* _____ _____
- ☐ HEARING AIDS ☐ *Left* ☐ *Right* ☐ *Both* _____ _____
- ☐ COLD SORES/HERPES SIMPLEX _____ _____
- ☐ SEASONAL ALLERGIES _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

CARDIOVASCULAR — START DATE — STOP DATE

- ☐ HIGH BLOOD PRESSURE _____ _____
- ☐ CHEST PAIN _____ _____
- ☐ HEART ATTACK (MI) _____ _____
- ☐ HEART MURMUR _____ _____
- ☐ CONGESTIVE HEART FAILURE - (CHF) _____ _____
- ☐ EDEMA _____ _____
- ☐ CORONARY ARTERY DISEASE _____ _____
- ☐ ATRIAL FIBRILLATION _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

DERMATOLOGIC *(SKIN CONDITIONS)* — START DATE — STOP DATE

- ☐ SKIN CANCER _____ _____
  ☐ *Basal* ☐ *Squamous* ☐ *Melanoma*
- ☐ ECZEMA/ATOPIC DERMATITIS _____ _____
- ☐ RASH _____ _____
- ☐ ROSACEA _____ _____
- ☐ PSORIASIS (Thick, Scaly Skin Patches) _____ _____
- ☐ ACNE _____ _____
- ☐ ACTINIC KERATOSIS (AK) - sun damage _____ _____
- ☐ HYPERHIDROSIS _____ _____
- ☐ HIDRADENITIS SUPPURATIVA (HS) _____ _____
- ☐ WARTS _____ _____
- ☐ CHRONIC SPONTANEOUS URTICARIA _____ _____
- ☐ CHRONIC INDUCIBLE URTICARIA _____ _____
- ☐ ALOPECIA AREATA _____ _____
- ☐ MALE PATTERN BALDNESS _____ _____
- ☐ FEMALE PATTERN HAIR LOSS _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

DIGESTIVE SYSTEM/LIVER — START DATE — STOP DATE

- ☐ HEARTBURN/GERD _____ _____
- ☐ IRRITABLE BOWEL SYNDROME _____ _____
- ☐ CROHN'S DISEASE _____ _____
- ☐ DIVERTICULITIS _____ _____
- ☐ ULCERATIVE COLITIS _____ _____
- ☐ HEPATITIS ☐ *A* ☐ *B* ☐ *C* _____ _____
- ☐ CIRRHOSIS OF THE LIVER _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

ENDOCRINE/METABOLIC — START DATE — STOP DATE

- ☐ DIABETES - TYPE I _____ _____
- ☐ DIABETES - TYPE II _____ _____
- ☐ HYPOGLYCEMIA (Low Blood Sugar) _____ _____
- ☐ HYPOTHYROIDISM (Under Active) _____ _____
- ☐ HYPERTHYROIDISM (Over Active) _____ _____
- ☐ OBESITY _____ _____
- ☐ HIGH CHOLESTEROL _____ _____
- ☐ HIGH TRIGLYCERIDES _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

URINARY / RENAL — START DATE — STOP DATE

- ☐ RECURRENT URINARY TRACT INFECTION _____ _____
- ☐ KIDNEY STONES _____ _____
- ☐ POLYURIA (Frequent Urination) _____ _____
- ☐ INCONTINENCE _____ _____
- ☐ CHRONIC KIDNEY DISEASE _____ _____
- ☐ CHRONIC RENAL INSUFFICIENCY _____ _____
- ☐ KIDNEY FAILURE _____ _____
- ☐ DIALYSIS _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

RESPIRATORY — START DATE — STOP DATE

- ☐ SLEEP APNEA _____ _____
- ☐ ASTHMA _____ _____
- ☐ CHRONIC BRONCHITIS _____ _____
- ☐ EMPHYSEMA (Lung Disease) _____ _____
- ☐ SHORTNESS OF BREATH _____ _____
- ☐ PNEUMONIA _____ _____
- ☐ TUBERCULOSIS _____ _____
- ☐ OTHER: _____ _____ _____
- ☐ NONE OF THE ABOVE

BLOOD DISORDERS | START DATE | STOP DATE

- ☐ ANEMIA
- ☐ HIV POSITIVE
- ☐ AIDS
- ☐ POLYCYTHEMIA VERA
- ☐ THROMBOCYTOPENIA
- ☐ PULMONARY EMBOLISM
- ☐ DEEP VEIN THROMBOSIS – DVT/BLOOD CLOTS: Specify Location: _____
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

PSYCHOLOGICAL | START DATE | STOP DATE

- ☐ DEPRESSION
- ☐ ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
- ☐ INSOMNIA
- ☐ ANXIETY
- ☐ POST-TRAUMATIC STRESS DISORDER (PTSD)
- ☐ BIPOLAR DISORDER
- ☐ SCHIZOPHRENIA
- ☐ OBSESSIVE COMPULSIVE DISORDER
- ☐ AUTISM
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

NEUROLOGICAL | START DATE | STOP DATE

- ☐ MIGRAINES
- ☐ FIBROMYALGIA
- ☐ PARKINSON'S DISEASE
- ☐ ALZHEIMER'S
- ☐ FAINTING
- ☐ SEIZURES
- ☐ STROKE
- ☐ HEADACHES
- ☐ NEUROPATHY
  Specify: _____
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

MUSCULOSKELETAL | START DATE | STOP DATE

- ☐ OSTEOPOROSIS
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ PSORIATIC ARTHRITIS
- ☐ GOUT
- ☐ BACK PAIN
- ☐ MUSCLE PAIN
- ☐ MULTIPLE SCLEROSIS
- ☐ LUPUS
- ☐ FRACTURES WITH HARDWARE PLACEMENT
  Specify: _____
- ☐ JOINT REPLACEMENT
  Specify: _____
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

IF APPLICABLE

FEMALE REPRODUCTIVE | START DATE | STOP DATE

- ☐ BREAST CANCER
- ☐ OVARIAN CYSTS
- ☐ ENDOMETRIOSIS
- ☐ CERVICAL CANCER
- ☐ HEAVY MENSTRUAL BLEEDING
- ☐ RECURRENT YEAST INFECTION
- ☐ MENOPAUSE
- ☐ BACTERIAL VAGINOSIS
- ☐ POLYCYSTIC OVARIAN SYNDROME (PCOS)
- ☐ CHLAMYDIA
- ☐ GENITAL WARTS
- ☐ GENITAL HERPES
- ☐ SYPHILIS
- ☐ GONORRHEA
- ☐ POST MENOPAUSE
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

FEMALE SURGERY & BIRTH CONTROL | START DATE | STOP DATE

- ☐ HYSTERECTOMY – PARTIAL
- ☐ HYSTERECTOMY – COMPLETE
- ☐ OOPHORECTOMY (Ovaries Removed)
- ☐ BILATERAL TUBAL LIGATION
- ☐ BILATERAL TUBAL OCCLUSION
- ☐ BILATERAL TUBAL REMOVAL
- ☐ BIRTH CONTROL METHODS:
  Specify: _____
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

MALE REPRODUCTIVE/ SURGERY | START DATE | STOP DATE

- ☐ ENLARGED PROSTATE
- ☐ PROSTATE CANCER
- ☐ TRANSURETHRAL RESECTION OF THE PROSTATE (TURP)
- ☐ TESTICULAR CANCER
- ☐ ERECTILE DYSFUNCTION (Impotence)
- ☐ GONORRHEA
- ☐ CHLAMYDIA
- ☐ GENITAL WARTS
- ☐ GENITAL HERPES
- ☐ SYPHILIS
- ☐ VASECTOMY
- ☐ PROSTATE REMOVAL
- ☐ OTHER: _____
- ☐ NONE OF THE ABOVE

TOBACCO HISTORY	START DATE	STOP DATE
☐ NEVER USED		
☐ CURRENTLY USE	_____	_____
Type of Tobacco: _____		
How much: _____		
☐ USED TOBACCO IN THE PAST	_____	_____
Type of Tobacco: _____		
How much: _____		

ALCOHOL HISTORY	START DATE	STOP DATE
☐ NEVER CONSUMED		
☐ CURRENTLY CONSUME	_____	_____
Frequency: _____		
☐ CONSUMED ALCOHOL IN THE PAST	_____	_____
Last year consumed: _____		

MEDICATIONS

(List all medications and supplements you are currently taking/using.)

☐ **NO MEDICATIONS**

MEDICATION NAME	DOSAGE STRENGTH OF MED *(MCG/MG)*	FREQUENCY TIMES PER DAY/ WEEK/MONTH	START DATE	REASON TAKING/USING

DRUG ALLERGIES

☐ **NO KNOWN DRUG ALLERGIES**

DRUG ALLERGIES	DATE ALLERGY WAS DISCOVERED	REACTION TO DRUG (HIVES, NAUSEA, ANAPHYLAXIS, ITCHING, ETC.)

SURGERIES

☐ NO SURGERIES

DATE	SURGERY	REASON FOR THE SURGERY

SPECIFICS ABOUT YOUR STUDY VISIT

Specify the type of study are you here for *(Skin Condition, i.e., psoriasis, AK, acne, etc.)*: _____

PRIOR TREATMENTS	DATE/S OF TREATMENTS	RESULTS (helped, didn't help, etc.)

PATIENT SIGNATURE

I certify that I understand the importance of providing complete and accurate information. I have completed this form to the best of my knowledge. It represents all medical conditions that I have had or currently have and includes all prescription or over-the-counter medications that I take.

Signature: _____ *Date:* _____

STAFF SIGNATURE

I have reviewed the information with the study volunteer, answered questions and provided assistance as needed.

Signature: _____ *Date:* _____