

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

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 18 YEARS OLD, PLEASE PROVIDE LEGAL GUARDIAN'S INFORMATION:

NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RELATIONSHIP: _____

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. Guenther/DCI
- Another Dr.'s Office: Who? _____
- Other (Please specify): _____

INSTRUCTIONS:

- CHECK Diseases or Conditions you now have or have been diagnosed with in the past.**
- If none apply, please check "NONE OF THE ABOVE".**
- 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.**
- 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 _____

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 _____

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 _____

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 _____

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 _____

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

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

START DATE **STOP DATE**

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PSYCHOLOGICAL

- 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

START DATE **STOP DATE**

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NEUROLOGICAL

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

START DATE **STOP DATE**

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MUSCULOSKELETAL

- 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

START DATE **STOP DATE**

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IF APPLICABLE**FEMALE REPRODUCTIVE**

- 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

START DATE **STOP DATE**

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FEMALE SURGERY & BIRTH CONTROL

- 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

START DATE **STOP DATE**

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MALE REPRODUCTIVE/ SURGERY

- 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

START DATE **STOP DATE**

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SURGERIES

NO SURGERIES

DATE	SURGERY	REASON FOR THE SURGERY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

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.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____

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: _____