Options Research Group, LLC 124 Sagamore Parkway West West Lafayette, IN 47906

	Confidential Subject Information																
F	Patient ID #		SSN					Race/ Ethnicity	□ W □ As	sian	_ E	Black		ispanio on-His		ic	
	First Name					M.I.		Last Na	ame								
	Nickname			D.O.	.В			Marital S	atus	□ Single□ Divore□ Widow	ced	Married		Sex		М	∃ F
	Address						<u> </u>										
	City					St	ate		z	ip Cod	le						
	ome Phone							Cell Phone									
V	Work/Other Phone							Email									
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					P	hysicia	an In	formation									
	Primary Care Physician						Refe	rring Physician (f applic	able)							
	Address																
Cit	ty/State/Zip							Phone									
		Parent or Legal Guardian (if patient is under 18) Information															
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Protocol:	Subject #:	Initials:	Date:
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SELF REPORTED PERSONAL MEDICAL HISTORY

PLEASE LIST ALL MEDICAL CONDITIONS INCLUDING <u>DATE OF DIAGNOSIS</u>:

Yes	No		Date	Yes	No		Date
		Cardiovascular High Blood Pressure High Cholesterol				Eye Cataracts	
		Congestive Heart Failure				Glaucoma	
		Heart Attack Irregular Heart Rhythm				Neurologic/Psychiatric Seizures/Epilepsy	2
		Heart Valve Disease/ Replacement				Stroke Migraines	
		Defibrillator / Pacemaker		Ш		wigianies	
П	П	Pulmonary Asthma				Depression Anxiety	
		Emphysema				Suicide attempt	
		Tuberculosis COPD		П		Endocrine Hypothyroid	
		Renal/Kidney				Hyperthyroid	
	\Box	Renal Insufficiency Dialysis				Diabetes Type I Diabetes Type II	
		Kidney Stones			Ш	Musculoskeletal	
		Liver/Gastrointestina	<u>l</u>			Osteoporosis	
		Hepatitis Cirrhosis				Rheumatoid Arthritis Psoriatic Arthritis	
		Gall Stones Peptic Ulcers				Osteoarthritis General	
		Ulcerative Colitis				Insomnia	
	\Box	Irritable Bowel syndrome GERD				AIDS/HIV+ Hepatitis B or C	
		Crohn's disease		Ä	Ĭ	Gout	
		Skin				Seasonal Allergies	
		Psoriasis					
	\exists	Acne Rosacea					
		Atopic Dermatitis/Eczema					
		History of Cancer (Type	pe):				
		Females				Males	
		Postmenopausal x 2 yrs				Vasectomy	
		Surgically Sterile Birth Control				Partner post menopause Partner Surgically sterile	
Contrace	eption Met	hod:					
Alcoho	l Use:	Yes No If Yes:	How many drinks _ pe:		er Week /	Month/Year How Long:	
Tobacc	o Use:	☐ Yes ☐ No If Yes:	pe:	Day / We	eek	How Long:	
Any of	her medi	cal history not previously	addressed:				
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Protocol:Sub	oject #:	Initials:	Date:
PREVIOUS SURGERIES:			
Name of Surgery:	Date:	Reason:	
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IEDICATIONS (Including all over Medication Name:	_	Reason taken:) Start Date:
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0			
LLERGIES TO MEDICATIONS:			
·	2	3	
	5	6	
			
Patient Signature	Date	Coordinator Signature	Date