

**Confidential Subject Information**

<b>Patient ID #</b> <i>(if DFDG pt)</i>		<b>SSN</b>		<b>Race/ Ethnicity</b>	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
<b>First Name</b>		<b>M.I.</b>		<b>Last Name</b>			
<b>Nickname</b>		<b>D.O.B</b>		<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Married	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Address</b>							
<b>City</b>		<b>State</b>		<b>Zip Code</b>			
<b>Home Phone</b>				<b>Cell Phone</b>			
<b>Work/Other Phone</b>				<b>Email</b>			
<b>Best way to contact you?</b>	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work/Other <input type="checkbox"/> Email			<b>Best time to contact you?</b>			
<b>How did you hear about us?</b>				<b>Prior Study Experience</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclusionary? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Physician Information**

<b>Primary Care Physician</b>		<b>Referring Physician (if applicable)</b>	
<b>Address</b>			
<b>City/State/Zip</b>		<b>Phone</b>	

**Parent or Legal Guardian (if patient is under 18) Information**

<b>First Name</b>		<b>M.I.</b>		<b>Last Name</b>			
<b>Relationship to Subject</b>		<b>D.O.B</b>		<b>SSN</b>			
<b>Address</b>							
<b>City</b>		<b>State</b>		<b>Zip Code</b>			
<b>Home Phone</b>				<b>Cell Phone</b>			

**Insurance Information**

(In order for compensation, answer is required)

<b>Is the research participant a Medicare beneficiary?</b>	<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
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**Emergency / Information Contact**

<b>Name</b>		<b>Phone Number</b>	
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**Thank you for participating in our clinical studies!**

May we send you appointment reminder texts to your phone?  Yes  No  
 May we contact you for future studies including email?  Yes  No

I acknowledge a receipt of a copy of Notice of Privacy Practices.  
 I give consent and authorization for the staff of the Clinical Research office to leave Protected Health Care Information about me or for me on my answering machine or voicemail via the telephone number I have listed. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

<b>Date</b>		<b>Subject Signature</b> (Parent/Legal Guardian if applicable)	
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**Options Research Group, LLC  
124 Sagamore Parkway West  
West Lafayette, IN 47906**

Protocol: \_\_\_\_\_ Subject #: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**SELF REPORTED PERSONAL MEDICAL HISTORY**

**PLEASE LIST ALL MEDICAL CONDITIONS INCLUDING DATE OF DIAGNOSIS:**

Yes	No		Date	Yes	No		Date
<b><u>Cardiovascular</u></b>				<b><u>Eye</u></b>			
<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	_____	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Neurologic/Psychiatric</u></b>	
<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 Disease/ Replacement	_____	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	_____
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator / Pacemaker	_____	<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<b><u>Pulmonary</u></b>				<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Endocrine</u></b>	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	_____
<input type="checkbox"/>	<input type="checkbox"/>	COPD	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	_____
<b><u>Renal/Kidney</u></b>				<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I	_____
<input type="checkbox"/>	<input type="checkbox"/>	Renal Insufficiency	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type II	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	_____	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Musculoskeletal</u></b>	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	_____	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____
<b><u>Liver/Gastrointestinal</u></b>				<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Psoriatic Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gall Stones	_____	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>General</u></b>	
<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	_____
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel syndrome	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	_____
<input type="checkbox"/>	<input type="checkbox"/>	GERD	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gout	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	_____
<b><u>Skin</u></b>							
<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	_____				
<input type="checkbox"/>	<input type="checkbox"/>	<b>History of Cancer</b> (Type): _____					
<b><u>Females</u></b>				<b><u>Males</u></b>			
<input type="checkbox"/>	<input type="checkbox"/>	Postmenopausal x 2 yrs	_____	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgically Sterile	_____	<input type="checkbox"/>	<input type="checkbox"/>	Partner post menopause	_____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control	_____	<input type="checkbox"/>	<input type="checkbox"/>	Partner Surgically sterile	_____

Contraception Method: \_\_\_\_\_

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

**Tobacco Use:**  Yes  No If Yes: How many \_\_\_\_\_ Per Day / Week How Long: \_\_\_\_\_  
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. _____

_____	_____	_____	_____
Patient Signature	Date	Coordinator Signature	Date