ROCHESTER CLINICAL RESEARCH

Place Label Here

Patient Reported Medical History

PERSONAL INFORMATION

Name: _____ DOB: _____ Birth Sex: M☐ F☐ Gender: M☐ F☐ Other☐

Telephone Number: Occupation:

Primary Physician's Full Name: _____

LIFESTYLE

Nicotine ☐No ☐Former ☐ Yes, if yes: _____# Packs per Day, for _____years.

Alcohol ☐No ☐ Former ☐ Yes, if yes: _____# Drinks per Day, for _____years.

Exercise ☐ No ☐ Yes, if yes: _____ # of times per week.

FAMILY HISTORY

Relationship	Illnesses	Age at Death	Cause of Death
Father			
Mother			
Siblings: ☐ M ☐ F			
Siblings: ☐ M ☐ F			

MEDICATIONS

Medication	Frequency	Strength /Dose	Method	Start Date	Stop Date
Example: Simvastatin	1 x/day	20mg	Pill, drops, spray	5/2001	7/2011-OR-C*

---------- *If you are currently taking the medication, please write "C" ----------

ALLERGIES

Medication/Product	Describe Reaction	Year	NCS

HOSPITALIZATIONS, SURGERIES & PROCEDURES

Description	Year	NCS	Description	Year	NCS

GRAYED AREAS ARE FOR SITE STAFF USE ONLY

Place Label Here

Patient Reported Medical History

If condition is continuing, please write "C"

GRAYED AREAS ARE FOR SITE STAFF USE ONLY

√ Check all that Apply	Start Year	End Year	NCS
GENERAL			
☐ Allergies, Environmental			
☐ Insomnia			
☐ Overweight			
EYES, EARS, NOSE, THROAT			
☐ Glaucoma			
☐ Hearing Loss			
☐ Tinnitus [Ringing in Ears]			
RESPIRATORY/CHEST			
☐ Asthma			
☐ COPD/ Emphysema			
☐ Obstructive Sleep Apnea			
☐ Tuberculosis			
CARDIOVASCULAR			
☐ Arrhythmia [Irregular Heart Beat]			
☐ Edema [Swelling of Feet]			
☐ Heart Attack /Coronary Artery Disease			
☐ Heart Failure			
☐ Heart Valve Problems			
☐ High Blood Pressure			
☐ Venous Thrombosis [Clots] /Phlebitis			
GASTROINTESTINAL			
☐ GERD [Acid Reflux/Heartburn]			
☐ Hepatitis			
☐ Irritable Bowel Syndrome			
☐ Crohn's/Ulcerative Colitis			
☐ Liver Disease			
☐ Ulcer Disease			
URINARY/RENAL			
☐ Hematuria [Blood in Urine]			
☐ Kidney Stones			
☐ Urinary Incontinence [Leaking Urine]			
FEMALES (REPRODUCTIVE/SEXUAL)			
☐ Age at Menopause			
☐ Menopausal Symptoms			
☐ Irregular Periods			
☐ Sexual Difficulties			
☐ Last Mammogram Date:			
☐ Last Pap Smear Date:			

√ Check all that Apply	Start Year	End Year	NCS
MALES (REPRODUCTIVE/SEXUAL)			
☐ Prostate Enlargement			
☐ Sexual Difficulties			
ENDOCRINE/METABOLIC			
☐ Diabetes			
☐ High Cholesterol			
☐ High Triglycerides			
☐ Thyroid Disease/Nodule			
NEUROLOGICAL			
☐ Diabetic/ Other Neuropathy			
☐ Headaches [Tension/Stress]			
☐ Migraine Headaches w/o Aura			
☐ Migraine Headaches w/ Aura			
☐ Seizure Disorder			
☐ Stroke			
☐ Vertigo [Dizziness]			
MENTAL HEALTH			
☐ Anxiety			
☐ Bipolar Disorder			
☐ Depression			
MUSCULOSKELETAL			
☐ Gout			
☐ Low Back Pain			
☐ Osteoarthritis			
☐ Osteoporosis			
☐ Rheumatoid Arthritis			
SKIN			
☐ Cold Sores			
☐ Rosacea			
☐ Eczema			
☐ Hives			
☐ Psoriasis			
BLOOD (HEMATOLOGIC)			
☐ Anemia			
CANCER (MALIGNANCIES)			
Specify:			
Specify:			
Specify:			

Study Participant's Signature:
(Upon Completion or updating of form, sign & date next available line)

Medical Provider's Signature:

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____