ClinSearch
Clinical Research Specialists

DR. RICHARD A. KRAUSE, MEDICAL DIRECTOR

Patient Information Sheet

Date: _____ SS # _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home or Cell #: _____ Work #: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Name of your Family Doctor: _____

☐ I request that my records of my research participation be sent to my doctor.

☐ No, I do not want my records of my research participation to be sent to my doctor.

_____ _____

Signature Date

(Circle One)

Marital Status: Single Married Divorced Widowed

(Optional) Race: _____ Gender: Male Female

Name of Employer: _____

Spouse's Name: _____

What kind of problems are you having? _____

How long have you had this problem? _____

May we have your permission to put your information into our database for future research studies?
Yes No

CONTACT PERSON IN CASE OF EMERGENCY (Person NOT Living with you)
Name: _____

Address: _____City, State, Zip: _____

Relationship: _____ Phone #: _____

Where did you hear about us? _____

Your Initials: _____

Please list all medications you are currently taking, include any:

*__Prescribed by a Doctor__
*__Vitamins or Herbal Supplements__
*__Over-the-Counter Medications__

Note:
***If specific dates are not known, please estimate. Also include any medications that have been discontinued in the last 30 days.**

Medication	Reason	Dose	How often	Start Date M/D/Y	Stop Date M/D/Y

List any allergies you might have to medication or food:

__Medication/Food__	__Reaction__
_____	_____
_____	_____

Please list any and ALL surgeries you have had.

Surgery	Reason	Year

Your Initials:_____

Please check all that apply to you:

Have you seen Dr. Krause as a patient (outside of research)? _____

General Health:

__Fatigue
__Anxiety or Depression
__Insomnia
__High Cholesterol
__Alcohol Use ___ Drinks per week

__Headaches: Circle each that applies: Migraine, Tension, Sinus
__Edema (swelling) Please list all body sites that this applies:
_____

Eyes, Ears, Nose, Throat:

__Sinusitis
__Seasonal Allergies
__Cataracts
__Glaucoma
__Hearing Loss
__Dry Eyes
__Conjunctivitis
__Eye glasses or contacts
__Vision Problems: _____
__Other:_____

Respiratory:

__Asthma
__Bronchitis
__COPD
__Wheezing or Shortness of Breath
__ Persistent Cough
__Positive TB test
__Pneumonia
__Smoker____ Pks/day ____How many years
__Other: _____

Cardiovascular:

__Heart Murmur
__Angina
__Heart Attack
__High Blood Pressure
__Stroke
__Irregular Heart Beat
__Placement of a stint
__Other:_____

Gastrointestinal:

__Stomach Ulcer
__Gallstones
__Heartburn, Esophagitis, Reflux
__IBS
__Constipation, Diarrhea
__Hernia: Inguinal or Hiatal
__Hemorrhoids
__Other:_____

Genitourinary: Women:

__Kidney Stones
__Urinary Tract Infections
__Hysterectomy: Total or Partial
__Endometriosis
__Cysts
__Fibroid Tumors
__Age at 1st cycle____Age at last cycle____
__Tubal Ligation
__Other:_____

Men:

__Kidney Stones
__Urinary Tract Infections
__Prostate Problems: _____
__Erectile Dysfunction
__Other:_____

Endocrine:

__Hypothyroidism
__Hyperthyroidism
__Diabetes
__Other:_____

Musculoskeletal:

__OsteoArthritis Where:_____
__Rheumatoid Arthritis
__Carpal Tunnel Syndrome
__Osteoporosis
__Osteopenia
__Rotator Cuff
__Other:_____

Hematology:

__Anemia
__Hepatitis
__Sickle Cell Anemia
__Other:_____