ClinSearch
Clinical Research Specialists

Patient Information Sheet

May we have your permission to text your cell phone a reminder of your appointment? **Yes No (please circle one)**

Date: _____ SS # _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone Home#: _____ Cell #: _____

Work # _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

(Optional) Race: _____ Gender: Male Female

Marital Status: Single Married Divorced Widowed

Name of your Primary Physician _____

Physician Phone# _____ **FAX#** _____

_____ _____

Signature **Date**

_____

(Study related)What kind of problems are you having? _____

_____

How long have you had this problem?

Contact person in case of Emergency

Name: _____

Address: _____ City, State, Zip: _____

Relationship: _____ Phone #: _____

Where did you hear about us? _____

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Date:_____ Your Initials: _____

Please list all medications you are currently taking, include any:
Prescribed by a Doctor, Vitamins or Herbal Supplements, OTC Meds.
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

Date:_____ **Your Initials:**_____

General Health:

__Fatigue
__Anxiety
__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: _____

Cardiovascular:

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

Hematology:

__Carpal Tunnel Syndrome
__Anemia
__Hepatitis
__Sickle Cell Anemia

Genitourinary: Women:

__Kidney Stones
__Urinary Tract Infections
__Hysterectomy: Total or Partial
__Endometriosis
__Cysts
__Fibroid Tumors
__Tubal Ligation
__Other:_____

Musculoskeletal:

__OsteoArthritis Where:_____
__Rheumatoid Arthritis
__Osteoporosis
__Osteopenia
__Rotator Cuff

Respiratory:

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

Gastrointestinal:

__Stomach Ulcer
__Gallstones
__ GERD, Reflux
__Heartburn, Esophagitis,
__IBS
__Constipation,
__Diarrhea
__Celiac
__Ulcerative Colitis
__Gastroparesis
__ Crohn's
__Hemorrhoids
__Hernia: Inguinal or Hiatal

Men:

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

Endocrine:

__Hypothyroidism
__Hyperthyroidism
__Diabetes Type 1
__Diabetes Type 2

Other not listed _____

_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization is extended to provide protection for individual rights under Federal Laws, Title 42, Chapter 11, Part II. The following guidelines are agreed upon:

- This document provides consent for release of professional medical information
- This request is limited to the person or agency listed
- The information will not be passed on to anyone else or used for any purpose other than as specified
- This consent can be revoked at anytime. Any information released prior to such a revocation shall not be considered a violation of the right of confidentiality
- The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of information requested below to the extent indicated and authorized below to the extent indicated and authorized below
- A copy of this release is as valid as the original

I hereby authorize _____
(Name of your Physician/Institution)

to release the following information from my health record:

Patient Name _____

Date of Birth _____ **SS #** _____

Patient Signature _____ **Date** _____

Physician Phone: _____ **Fax:** _____

**** Note to the Medical Records Department****
If there is a fee for processing medical records, please contact office before sending.

(The following is for ClinSearch use)

1st Attempt _____ 2nd Attempt _____ 3rd Attempt _____

Requesting Study Coordinator _____