

CASTLEROCK CLINICAL RESEARCH

Medical History Questionnaire

Name: _____ Physician: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email address: _____ SS #: _____

Would you like notification of future trials? YES NO

PERSONAL CONTACT NOT LIVING IN HOME:

Name: _____ Phone #: _____

Address: _____ City/State: _____

DEMOGRAPHIC INFORMATION

Date of Birth: _____ Height: _____ Weight: _____ Gender: M F

Caucasian African American Asian Hispanic Native American Other _____

MEDICAL INFORMATION: (Have you ever had any of these problems?)

	Year		Year
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Hernias	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Lung Disease	_____
<input type="checkbox"/> Vascular Disease	_____	<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Narrowing	_____	<input type="checkbox"/> Bronchitis	_____
<input type="checkbox"/> Blood Clots	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Inflammation	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Heart Murmur	_____	<input type="checkbox"/> Abnormal Chest X-Ray	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Rhythm Problems	_____	<input type="checkbox"/> Urinary Tract Problems	_____
<input type="checkbox"/> Varicose Veins	_____	<input type="checkbox"/> Reproductive Problems	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Headache	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Skin Disease	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> (rash, nail fungus, acne, etc)	_____
<input type="checkbox"/> Elevated Cholesterol	_____	<input type="checkbox"/> Chronic Pain	_____
<input type="checkbox"/> Autoimmune Disorders	_____	<input type="checkbox"/> Edema	_____
<input type="checkbox"/> Epilepsy or Convulsions	_____	<input type="checkbox"/> Trauma/Accidents	_____
<input type="checkbox"/> Alzheimers Disease	_____	<input type="checkbox"/> Obesity	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Diarrhea	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Constipation	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> "Heartburn"	_____
<input type="checkbox"/> Osteo	_____	<input type="checkbox"/> Seasonal Allergies	_____
<input type="checkbox"/> Rheumatoid	_____	<input type="checkbox"/> Insomnia	_____
<input type="checkbox"/> Thyroid Problems	_____	<input type="checkbox"/> _____	_____

PERSONAL HABITS

Drug /Alcohol Habits? How Much? _____ # of Years? _____
Tobacco Use? How Much? _____ # of Years? _____
Exercise regularly? Y N How Many Hours per week? _____
Activity? _____

PREVIOUS SURGERIES/ HOSPITALIZATIONS:

YEAR

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:

- Premature Heart Disease / Heart Attack (Under Age 50)
- High Blood Pressure
- High Cholesterol
- Diabetes
- Obesity
- Cancer

PRESCRIPTION MEDICINE

Dose

Indication

Date Started

PRESCRIPTION MEDICINE	Dose	Indication	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DIETARY SUPPLEMENTS, HERBAL SUPPLEMENTS, VITAMINS

ALLERGIES (Foods, Medicines, Animals, Toxins)

Reaction:

_____	_____
_____	_____
_____	_____

OTHER SIGNIFICANT HISTORY:

Signature _____

Date: _____