National Clinical Research-Richmond, Inc

Patient History

Today's Date: _____

Name: _____ _____

Address:_____

City:_____State: _____Zip code:_____

Home Phone:_____Business Phone:_____Usual work hours: _____

Cell phone #:_____E-mail address:_____

Present Physician: _____

Office address and phone #:_____

Closest relative to contact in case of emergency: _____

Phone number: _____

Demographic Information

Date of Birth _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female
month day year

Race: ☐ White ☐ Asian or Pacific Islander
☐ Black ☐ American Indian or Alaskan Native
☐ Hispanic (White or Black)
☐ Other, *(specify):*_____

Weight: _____ lbs Height:_____ ft _____inches

Demographic Information

Occupation: _____ Are you now retired? ☐Yes ☐No

Current Medications

Please complete the chart below for all your **current** medications, including over-the-counter medications used on a regular basis, and herbal or vitamin supplements. ***Continue on back if more space needed.***

Name	Reason	Total Daily Dose	Start Date

Previous Medications

As best as you can recall, please complete the chart below for any **previous** medications taken for *high blood pressure*, *diabetes*, *cholesterol*, *osteoporosis*, *arthritis*, or *hormones for menopause*. Please note any that you had a bad or allergic reaction to.

Name	Reason	Total Daily Dose	Start Date	Stop Date	Bad Reaction?

Are you **allergic** to any **medications**? Yes No If yes, list _____

Are you **allergic** to anything else (i.e. pollen, milk, cats)? Yes☐No☐If yes, list _____

_____

Do/did you use **tobacco**? ☐ Never ☐ In the past ☐Currently

If so: ☐Pipe ☐Cigars ☐ Chewing tobacco

Cigarettes How many cigarettes per day? _____

How long have you smoked cigarettes? _____Years

If in the past, when did you stop (year)? _____

Do you drink **alcoholic beverages?** Yes☐No☐

If so, please estimate the amount consumed **per week.**

_____Oz wine _____oz beer _____oz hard liquor

Do you **exercise** regularly? Yes☐No☐

If yes, what type of exercise do you do, how often each week, and how long each time?

_____

Please complete the following sections for any medical conditions that you have.

HIGH BLOOD PRESSURE

1. In what year were you first told that you had high blood pressure? _____
2. What was your most recent blood pressure? _____/_____ Date _____

HIGH CHOLESTEROL

1. In what year were you first told that you had high cholesterol? _____
2. What was your cholesterol BEFORE starting diet or medication? _____
3. What was your most recent cholesterol level? _____ Date _____
4. Do you follow a low fat, low cholesterol diet?

☐Strictly ☐so-so ☐not at all

DIABETES

1. In what year were you first told that you had diabetes? _____
2. Is it TYPE 1 _____ or TYPE 2 _____?
3. Do you monitor your blood sugar at home? Yes ☐ No ☐
   If YES, about how often do you check it? _____
   What is your usual FASTING blood sugar? _____
4. What was your most recent FASTING blood sugar? _____ Date _____
5. What was your most recent Hemoglobin A1C? _____ Date _____

CARDIOVASCULAR DISEASE

Please list the date of any of the following you have had:

heart attack _____ stroke _____
angina _____ heart failure _____
heart bypass surgery _____ blood clots in lungs or leg VEINS _____
other artery bypass (leg, neck) _____

EMPHYSEMA / CHRONIC BRONCHITIS / ASTHMA

1. In what year were you first told you had this? _____
2. Have you ever had pulmonary function tests (breathing tests) done? Yes☐No ☐
   Date _____ Where performed? _____

GYNECOLOGIC HISTORY (If male, advance to Other Health Problems on next page)

If you have NOT gone through menopause yet, please check what birth control method you use currently:

_____ Birth control pills
_____ Barrier method (condom, diaphragm)
_____ IUD
_____ Abstinence
_____ Partner has had a vasectomy
_____ Other: _____

Have you had a hysterectomy (surgical removal of the uterus)? Yes☐No ☐ Date: _____
If yes, were the ovaries also removed? Yes☐No☐ Date: _____
If yes, were ONE or BOTH ovaries removed?

If you have gone through menopause, please indicate the month and year to the best of your knowledge: _____ How old were you? _____
Do you have hot flashes? Yes☐No☐ If yes, average number of daily (including night)_____

Have you taken any of the following since menopause?

_____ Hormones (estrogen &/or progestin)
Name, dose, dates if known: _____
_____
_____ Alendronate (brand name Fosamax), risedronate (Actonel) Dates: _____
_____ Raloxifene (Evista) Dates: _____
_____ Calcitonin (Miacalcin) Dates: _____

Osteoporosis Assessment

Do you eat dairy products (milk, cheese, ice cream, etc)? ☐ No ☐ some ☐ a lot

Do you take calcium or Vitamin D supplements? Yes☐ No ☐
If yes, please give name, dose, and for how long? _____
_____

About how many cups (8 oz) of caffeine-containing beverages (coffee, tea, sodas) do
you drink daily? _____

Have you ever broken a bone? Yes☐No☐
If yes, which bone(s) and when? _____

Have you taken any of the following on a regular basis?

_____ steroid medications (i.e. Prednisone, cortisone, etc) Dates: _____
_____ thyroid medicaton (i.e. Synthroid) Dates: _____
_____ seizure medication (i.e. Dilantin, phenobarbital) Dates: _____

Do osteoporosis or hip fractures run in your family? Yes☐No☐

If yes, in which blood relatives? _____

DEXA Scan Factors

Have you had a DEXA bone density scan before? Yes☐No☐ Dates: _____

Do you have: _____ dentures _____ pacemaker

Have you had in the past 3 days: _____ calcium *tablets* _____ a barium test
_____ a nuclear medicine scan

Have you ever had: _____ lower back surgery _____ gall bladder surgery
_____ kidney surgery (left /right)

Other Health Problems

Please provide dates and details here of any other health problems you have now or had in the past:

_____
_____
_____
_____
_____
_____
_____
_____

Hospitalizations and Operations

Please list all hospitalizations and operations you have had, including dates:

_____
_____
_____
_____
_____
_____
_____
_____

Family Medical History

If any of your *brothers, sisters, parents,* or *children* are deceased, please list their age and cause of death:

_____
_____
_____

Please list any other *blood relatives* who have, or have died with the following:

Stroke or heart attack under age 65 _____
Cancer (list type) _____
Diabetes _____
High blood pressure _____
High cholesterol _____
Blood clots in VEINS of leg or lung _____
Osteoporosis or hip fracture _____