ACRC TRIALS
Today's Research. Tomorrow's Medicine.

New Patient Paperwork

Please complete this paperwork in its entirety.

Personal Information

Full name:	
Nickname:	
Home address:	
Home phone:	
Mobile or cellular phone:	☐ Allow Text messages
Email Address:	
Sex ☐ Male ☐ Female	
Birthday (MM/DD/YYYY):	Age:
SSN:	
Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native	
Marital Status:	
How did you hear about us?	
Currently enrolled in another research study? ☐ Yes ☐ No	
Do we have your consent to request your medical records?	☐ Yes ☐ No
Do we have your consent to include you in our research database?	☐ Yes ☐ No
If Female, Are you or do you think you are pregnant?	☐ Yes ☐ No
Are you planning or attempting to get pregnant?	☐ Yes ☐ No
What type of birth control are you using?	_____
Are you post-menopausal?	☐ Yes, age of onset:___ ☐ No

Emergency and/or Guardian contact information

Emergency or Guardian Contact person:
Emergency or Guardian phone number:
Emergency or Guardian email:

Vaccinations

Have you received a COVID-19 vaccine?	☐ Yes ☐ No
If yes, date of last dose:	
Have you received a Flu (influenza) vaccine?	☐ Yes ☐ No
If yes, date of last dose:	

Family Medical History

☐ No significant family history is known.

Include any significant medical history for each family member.

☑	Condition	Family Member (s)
	Heart Disease/Attack	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Stroke	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Diabetes (Specify:_____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	High Blood Pressure	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	High Cholesterol	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Thyroid Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Depression	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Other Mental Illness (Specify:_____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Alcoholism	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Asthma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Osteoporosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Migraines	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Cancer (Specify:_____)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Other, specify:_____)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF

Prior/ Current Medications

Include any medications and/or vaccines received in the last 3 months. **Year is mandatory.**

Medication	Indication (Reason)	Dose	Dose (units)	Frequency	Medication Start Date

Medical History

Year is mandatory.

☑	Condition	Date of Diagnosis	☑	Condition	Date of Diagnosis
	Abnormal pap smear			Frequent Sinus Infections	
	Acne			Gallstones	
	ADD/ADHD			Glaucoma	
	Alcohol /Drug Abuse			Gout	
	Allergies (Seasonal or Medication-Specify: _____)			Heart Condition (Specify:_____)	
	Anemia			Headaches/ Migraines	
	Angina			Heart Attack	
	Anxiety/ Depression			Herpes	
	Arthritis Specify: _____			Hepatitis: (Specify A, B or C: _____)	
	Asthma			High Blood Pressure	
	Bipolar Disorder			High Cholesterol	
	Blood Clot or disorders (Specify:_____)			Immunodeficiency (HIV or Specify:_____)	
	Cancer (Specify:_____)			Kidney Disease(Specify:_____)	
	Cardiac Disease (Specify:_____)			Melanoma or Other skin cancer (Specify:_____)	
	Colon Polyps			Kidney Stones	
	Chron's Disease or IBS			Lupus	
	COPD			Kidney Infections	
	Chronic Bronchitis			Osteoarthritis	
	Colon Polyps			Osteopenia	
	Diabetes (Specify: _____)			Neurologic condition: (Specify: _____)	
	Diverticulitis			TB or Positive TB test	
	Ulcerative Colitis			Prostate Problems	
	Earaches			Psoriasis	
	Eating Disorders			Osteoporosis	
	Eczema			Reflux (Heartburn)/ Ulcers	
	Emphysema			Rheumatoid Arthritis	
	Frequent UTIs			Seizures	
	CVA /Stroke			STD (Specify: _____)	
	Thyroid Disease (Specify)			Warts or Other Skin conditions	

Hospitalization History

Year is mandatory.

Type of Admission (ER, ICU, Planned, etc)	Reason/Indication	Date(s)

Surgical History

Please include reason for surgery under Medical History. **Year is mandatory.**

☑	Procedure	Reason/ Indication	Date(s)	☑	Procedure	Reason/ Indication	Date(s)
	Appendectomy				Heart Surgery (Specify)		
	Arthroscopy				Hemorrhoids		
	☐ Back or ☐ Neck surgery				Hernia (Specify)		
	Cataract Surgery				Hysterectomy		
	☐ Tonsillectomy/ ☐ Adenoidectomy				☐ Knee or ☐ Hip Replacement		
	Gall Bladder Removal				☐ Mastectomy or ☐ Lumpectomy		
	Polyp Removal (Colon)				☐ Tubal Ligation/ ☐ Vasectomy		
	Cesarean Section				Other: _____		
	Plastic Surgery				Other: _____		

Social History

History of Smoking:	☐ Former (Date quit:_____)	☐ Current (Start Date:_____)	☐ Never
		Packs per day:	
Recreational Drug Use:	☐ Former (Date quit:___)	☐ Current (Start Date:_____)	☐ Never
Alcohol Use:	☐ Former (Date quit:_____)	☐ Current (Start Date:_____)	☐ Never
Caffeine Use:		☐ Former ☐ Current	☐ Never
Sexually Transmitted Disease:		☐ Yes, _____	☐ No
Recent Travel outside the US:		☐ Yes, _____	☐ No
Occupation:			

I confirm the above information is complete and if any new information comes about, I will inform the research team:

_____ _____

Patient Signature **Date**

ACRC TRIALS MEDICAL RECORDS RELEASE

PATIENTS: Please complete and fax to (972)-692-7713. Also, indicate the coordinator's name on the fax.

To: _____ Date: _____

_____

Physician or Hospital Name

City, State _____

Phone Number _____

Fax Number _____

I hereby authorize and request that you release my complete medical record and the following specific reports (if available):

- ✓ Medical Summary Page / Most Recent Clinic Visit
- ☐ Lab Results
- ☐ ECG
- ☐ Chest X-Ray / CT scan / MRI
- ☐ Medical Records from _____ to Present

Other:_____ _____

Patient Information

First Name: _____ Last Name: _____

SS#: _____ DOB: _____

Address (Street, City, State, Zip): _____

Patient Signature: _____

Date: _____

Please send this information to:

ACRC Trials

Attention: Clinical Research Coordinator

5655 W Spring Creek Pkwy, suite 125, Plano, TX 75024

☎ 972-354-1520

Fax: 972-692-7713

Notes:

Please fax the completed form to (972)692-7713.