ACRC TRIALS

NEW PATIENT INFORMATION FORM

PART I

1. For all household members less than 18 years of age, please provide the necessary contact person information (name, phone number, relationship).
2. If providing a home and work number, please place a ☑ in the box where you prefer to be contacted.
3. Please print all information.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me by the doctor and staff be handled as follows:

Patient Name: _____
First MI Last

Parent/Guardian Name: _____ Are you the legal guardian? ☐Yes ☐No
First MI Last

DOB: _____ Age: _____ Sex: ☐Male ☐Female

For **WRITTEN** Communication Address to:

_____
Street City State Zip

For **ORAL** Communication Call:

Home: (____) _____ ☐Call here
Mobile: (____) _____ ☐Call here ☐Allow Text Message Carrier: _____
Work: (_ _) _____ May we leave a message? ☐Yes ☐No

Electronic Mail Communication Address to:

Email : _____

I wish to place the following restrictions on disclosure of my health information:

_____

Please check one: ☐Asian ☐African American ☐Caucasian ☐Hispanic Native

☐American/American Indian ☐Other: _____

Contact Person (if above is ≤ 18 years): _____

Phone: (_____)_____ Relationship: _____

PART II

1. Did a physician refer you to see us? ☐ Yes ☐ No
2. If Yes, Doctor's Name: _____

2. Do you have a primary physician? ☐ Yes ☐ No
   If Yes, do we have your consent to acquire the profile information necessary to participate in a clinical trial? ☐ Yes ☐ No
   Contact Information: _____
3. Do we have your consent to include this information in our database? ☐ Yes ☐ No
4. Do you have transportation (car, bus, etc.) available to you? ☐ Yes ☐ No
5. Are you currently enrolled in a research study? ☐ Yes ☐ No
6. Have you participated in a research study in the last four weeks? ☐ Yes ☐ No

PART III

1. VACCINATIONS

Have you received a COVID-19 vaccination in the last year? ☐ Yes ☐ No

If yes, Manufacturer: _____ Last dose date:____/____/___

Have you received a Flu vaccination in the last year? ☐ Yes ☐ No

If yes, Manufacturer: _____ Last dose date:____/____/___

2. MEDICATIONS: What prescription, vitamins, and over-the-counter medications do you **currently use or** have **used in the past three months**? Please be specific.

MEDICATION	REASON	DOSE	START DATE OF MEDICATION STOP DATE OF MEDICATION

3. MEDICAL HISTORY (Diagnosis)

Please tell me if you have any of the following **diagnoses**, either current or past.

☐Allergies Have you ever had an allergy skin test? ☐Yes ☐No
If yes, Date of Testing: _____ Physician's Name: _____
Have you ever been on allergy shots? ☐Yes ☐No
Have you had sinusitis? ☐Yes ☐No Frequency: _____

☐Asthma	☐Bronchitis
☐Congestive Heart Failure	☐Heart Attack
☐Alzheimer's Disease	☐Headaches, Migraine
☐Angina	☐Headaches, Not Migraine
☐Anxiety	☐Herpes
☐ Arthritis, □Osteo or □Rheumatoid	☐High Cholesterol
☐Arthritis, Unspecified	☐ High Blood Pressure
☐Cancer (exclude if current)	☐Irritable Bowel Syndrome
☐Cardiac Disease	☐Multiple Sclerosis
☐Glaucoma	☐Osteoporosis
☐Depression	☐Ulcer, Duodenal Ulcer, Gastric
☐Diabetes	☐Ulcer, Unspecified
☐Earaches	☐Colitis/Bowel Disease
☐Liver Disease	☐CNS/Neurologic Chronic Diarrhea
☐TB	☐Chicken pox /recent exposure to chickenpox.
☐Cataracts (subcapsular)	If immune okay.

Have you tested positive for: ☐HIV ☐Hepatitis B ☐Hepatitis C
OTHER: _____

4. FAMILY MEDICAL HISTORY

Father: _____ or ☐None
Mother: _____ or ☐None
Paternal
Grand Mother: _____ or ☐None
Grand Father: _____ or ☐None
Maternal
Grand Mother: _____ or ☐None
Grand Father: _____ or ☐None
Siblings: _____ or ☐None
Children: _____ or ☐None

5. SOCIAL HISTORY

How long have you lived in your current home? _____years _____months
Is there any obvious mold problem? ☐Yes ☐No
Type of flooring (include bathroom): _____

History of Smoking: ☐Non-smoker ☐Current smoker ☐Past smoker
If yes, how long?_____ Packs per day: _____
Prolonged cigarette smoke exposure: ☐Yes ☐No

Recreational Drug Use:	☐**Yes**	☐**No**	
Exercise:	☐**Yes**	☐**No**	
Caffeine:	☐**Yes**	☐**No**	Frequency: _____
Married:	☐**Yes**	☐**No**	Duration: _____
Alcohol:	☐**Yes**	☐**No**	If yes, type _____ frequency _____
Sexually Transmitted Disease:	☐ **Yes**	☐**No**	If yes, _____
Sexually Active:	☐**Yes**	☐**No**	
Travel outside US:	☐**Yes**	☐**No**	

Pets: ☐Dog ☐Cat ☐Other: _____ ☐Indoor ☐ Outdoor ☐ Both

Occupation _____ **Occup. Exposure:** _____

Have you been hospitalized in the past year? ☐Yes ☐No If yes, Please explain.

_____
_____

History of Surgery or Upcoming Surgeries:

_____
_____

Known **Allergies** to Medications (List names and symptoms):

_____
_____

Are you or do you think you may be pregnant? ☐Yes ☐No
Are you planning or attempting to become pregnant? ☐Yes ☐No

Are you post-menopausal? ☐Yes ☐ No If No, what type of birth control are you using to avoid pregnancy? _____

Patient (Guardian) Signature:_____ **Date** _____

Relationship to Patient: _____