# MEDICAL HISTORY

Omega Medical Research

## PERSONAL INFORMATION

**First Name**:_____**MI:**_____**Last Name:**_____

**DOB:**_____**Age:**_____**Gender: M or F (circle one)**

**Home Address:**_____**City**_____**State**_____**Zip** _____

**Cell Phone:**_____**Home Phone:**_____**Work Phone:**_____

**e-mail:**_____

**Race**: White:_____Black:_____Hispanic:_____ Asian: _____Native American:_____ Other:_____

**Emergency Contact:** Name:_____ Relationship:_____

Address:_____Phone:_____

**Primary Physician**: Name:_____

Phone:_____Fax:_____e-mail:_____

Address:_____

## FAMILY HISTORY

**Please list any family members (Mother, Father, Siblings or Grandparents) with significant medical history**

| Relationship | Describe | Age | Cause of Death if deceased: |
|---|---|---|---|
| | | | |
| | | | |

## MEDICATIONS

| Medication, check if none( ☐ none) | Indication of use | Strength and freq. | Method | Start Date | Stop Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## ALLERGIES OR REACTIONS TO MEDICATIONS

| Medication | Describe Reaction | Year |
|---|---|---|
| | | |
| | | |
| | | |

Patient Signature:_____

Date:_____



Reviewed By:_____

Date:_____

| HABITS |
|---|
| If yes, please describe type, amount and frequency |
| Tobacco **no** **yes** Packs per day _____, for years _____ |
| Alcohol **no** **yes** Drinks per day _____, for years _____ |
| Exercise **no** **yes** |
| Other **yes** |

| BIRTH CONTROL METHODS (FOR WOMEN ONLY) | | |
|---|---|---|
| **Methods of Birth Control** | | **Date** |
| Postmenopausal | **Date of last Menses** | |
| | **Hysterectomy** | |
| Surgically Sterile | **Bilateral Tubal Ligation** | |
| Barrier (diaphragm, sponge) | **Start date** | |
| Birth Control Pills | **Brand Name and Start Date** | |
| Condoms/Spermicide | **Start date** | |
| Rhythm Method | **Start date** | |
| Abstinence | **Start date** | |
| Partner with Vasectomy | **Start date** | |
| Same sex partner | **Start date** | |
| Other:_____ | **Start date** | |

| VACCINE HISTORY AND REACTIONS TO VACCINES | | |
|---|---|---|
| Have you had a Flu vaccine in the past 2 years? | Yes | No |
| Date of last flu vaccine? | Date:_____ | |
| Previous Vaccine Reactions? | Yes | No |
| Type of Reaction:_____ | | |
| History of anaphylactic type of reaction to consumption of eggs or eggs protein? | Yes | No |
| Type of Reaction:_____ | | |

**PAST AND PRESENT MEDICAL PROBLEMS**

| √ | Check all that apply | Year started | Year Ended | √ | Check all that apply | Year Started | Year Ended |
|---|---|---|---|---|---|---|---|
| | **LUNG, CHEST ( 0 none)** | | | | **ENDOCRINE, METABOLISM ( 0 none)** | | |
| | Cough | | | | Overweight, Obese | | |
| | Tuberculosis | | | | Diabetes mellitus | | |
| | Asthma | | | | High Cholesterol | | |
| | Emphysema | | | | High triglycerides | | |
| | Pneumonia | | | | Thyroid disease | | |
| | **HEART,CIRCULATION ( 0 none)** | | | | | | |
| | Angina | | | | **NERVOUS SYSTEM ( 0 none)** | | |
| | Heart Attack | | | | Seizures | | |
| | Irregular Heart Beat | | | | Stoke | | |
| | Heart Failure | | | | Paralysis | | |
| | Heart Murmur | | | | Carpal tunnel syndrome | | |
| | High Blood Pressure | | | | Neuropathy - specify below | | |
| | Blood Clots | | | | | | |
| | Varicose Veins | | | | Migraine | | |
| | Coronary Artery Disease | | | | Headache | | |
| | Peripheral Vascular Disease | | | | | | |

**PAST AND PRESENT MEDICAL PROBLEMS**

| √ | Check all that apply | Year started | Year Ended | √ | Check all that apply | Year Started | Year Ended |
|---|---|---|---|---|---|---|---|
| | | | | | **BEHAVIOR/MENTAL HEALTH ( 0 none)** | | |
| | | | | | Anxiety | | |
| | | | | | Depression | | |
| | **DIGESTION ( 0 none)** | | | | Bipolar | | |
| | Heartburn | | | | Alcoholism | | |
| | Acid Reflux | | | | Drug Abuse | | |
| | GERD | | | | Insomnia | | |
| | Ulcer Disease | | | | | | |
| | Irritable bowel syndrome | | | | **MUSCULOSKELETAL ( 0 none)** | | |
| | Diarrhea | | | | Sciatica | | |
| | Blood in stools | | | | Back Pain | | |
| | Jaundice/Hepatitis | | | | Arthritis of joints: specify below | | |
| | Gall stones | | | | | | |
| | Elevated liver function tests | | | | | | |
| | | | | | **Rheumatoid Arthritis ( 0 none)** | | |
| | | | | | Gout | | |
| | | | | | Osteoporosis | | |
| | | | | | | | |
| | **KIDNEY, URINE ( 0 none)** | | | | **SKIN ( 0 none)** | | |
| | Kidney, stones | | | | Eczema | | |
| | Frequent urination, over active bladder | | | | Dermatitis | | |
| | Difficulty in urination | | | | Psoriasis | | |
| | Urination at night | | | | Hives | | |
| | Incontinence | | | | Easy bruising | | |
| | Blood in urine | | | | Acne | | |
| | Infections | | | | Rosacea | | |
| | | | | | | | |
| | | | | | | | |
| | **FEMALES ( 0 none)** | | | | **BLOOD ( 0 none)** | | |
| | Irregular periods | | | | Anemia | | |
| | Heavy periods | | | | Bleeding tendency | | |
| | Menopausal symptoms | | | | | | |
| | Bleeding after menopause | | | | **CANCER ( 0 none)** | | |
| | Breast disease | | | | Cancer: Type/Location, s | | |
| | Sexual difficulties | | | | | | |
| | Most recent mammogram:_____ | | | | | | |
| | Most recent Pap smear:_____ | | | | Leukemia/Lymphoma | | |
| | # of pregnancies: _____ | | | | Skin Cancer | | |
| | | | | | Melanoma | | |
| | **MALES ( 0 none)** | | | | Breast Cancer | | |
| | Prostate enlargement | | | | Prostate Cancer | | |
| | Sexual difficulites | | | | Lung Cancer | | |
| | Vasectomy | | | | Colon Cancer | | |

**PAST AND PRESENT MEDICAL PROBLEMS**

| | OTHER, Including surgeries ( 0 none) | | | | EXTREMITIES ( 0 none) | | |
|---|---|---|---|---|---|---|---|
| | | | | | Color change | | |
| | | | | | Swelling | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Have you ever participated in a study here?** **Yes or No (circle one)**

If yes, which study_____Date ended:_____

**How did you learn about Omega Medical Research?**

Friend: _____ Radio Station:_____ Physician:_____

Other: _____ Newspaper: _____ Television Station:_____

**I understand that is is very important to give a true and complete medical history. I hereby attest that the information I have given Omega Medical Research is complete and accurate to the best of my knowledge. I understand that if I knowingly give false, incomplete or misleading information about my medical history (including past and present medications), this misrepresentation could have very serious consequences on my health and well-being. I also understand that this form will be used for the sole purpose of determining my eligibility to participate in a clinical research study.**

I **do do not (circle one)** wish to have my Primary Care Physician notified of my participation in a clinical research study.

I hereby acknowledge that I received a copy of Omega Medical Research's *Notice of Information Practices* .

**Patient Signature:_____ Date:_____**

| Review/Updated By | Date |
|---|---|
| | |
| | |
| | |
| Entered in CC by: | Date Entered: |