International Clinical Research – Tennessee LLC (IC Research)
PATIENT MEDICAL HISTORY FORM

Name:				**Who referred you to us?**			
Address:			**City:**		**State:**		**Zip:**
Telephone No.: Home – ( )				**Work – ( )**			
Cell – ( )			**Email Address:**				
Social Security No.:			**Date of Birth:**			**Age:**	
Occupation:			**Employed by:**				
Male: [ ] Female: [ ] Height:			**Weight:**				
Race: Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] American Indian [ ] Other:							
Who is your primary physician/family doctor?							
Who is your Specialty Physician (if you have one)?							
Emergency Contact:			**Their Tel. No.: ( )**		**Relationship:**		

What medications are you currently taking – prescriptions, over-the-counter, and vitamins?					**Have you taken any in the last …**		
Medication	**Dose**	**How often?**	**Started when?**	**Taken for what?**	**24 Hr?**	**30 Days?**	**6 Mo?**

Do you have Allergies? **If so, to what and when did they begin?**

Type of Reaction:

Are you Allergic to Latex?

Have you had any surgeries? **If so, please list the type of surgery and the date.**

Do you have any Stents or Implants?

Any other Hospitalizations? **If so, please list the reason and the date.**

Do you anticipate any surgery within the next six months? No [ ] Yes [ ]

If yes, what type of surgery?

Have you had any other serious illnesses?

Have you had any serious injuries?

Do you smoke? No [ ] Yes [ ] How much?

When did you start smoking? **When did you quit?**

Do you drink alcoholic beverages? No [ ] Yes [ ] How much?

Any history of substance abuse? No [ ] Yes [ ] What substance?

Have you had any of the following? If so, in what year?

Measles	**Mumps**	**Chicken Pox**
Rubella	**Scarlet Fever**	**Rheumatic Fever**
Pleurisy	**Polio**	**Malaria**
Tuberculosis	**Syphilis**	**Herpes**
Gonorrhea		

Patient Signature: _____

Date: _____

Please check below all health issues you may have had and indicate on the line (next to the issue) when (month and year) the issue began.

Example: ☑ Diabetes (Type 2) 10/2008

- ☐ Acne _____
- ☐ Allergies _____
- ☐ Anxiety/Panic Attacks _____
- ☐ Arthritis (knee, hand, hip, etc.) _____
- ☐ Asthma _____
- ☐ Athlete's Foot _____
- ☐ Back Pain _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Chronic Anemia _____
- ☐ Chronic Bronchitis _____
- ☐ Clotting Disorders _____
- ☐ Constipation _____
- ☐ COPD _____
- ☐ Cold Sores _____
- ☐ Crohn's Disease _____
- ☐ Depression _____
- ☐ Dermatitis _____
- ☐ Diabetes (Type 1) _____
- ☐ Diabetes (Type 2) _____
- ☐ Diabetic Neuropathy _____
- ☐ Diabetic Retinopathy _____
- ☐ Diarrhea (Irritable Bowel Syndrome) _____
- ☐ Diverticulosis _____
- ☐ Eczema _____
- ☐ Emphysema _____
- ☐ Erectile Dysfunction _____
- ☐ Hypoglycemia _____
- ☐ Impaired Hearing _____
- ☐ Irregular Heart Beat _____
- ☐ Insomnia _____
- ☐ Keratosis _____
- ☐ Kidney Stones _____
- ☐ Lasik Surgery _____
- ☐ Low Testosterone _____
- ☐ Lupus _____
- ☐ Macular Degeneration _____
- ☐ Migraine Headaches _____
- ☐ Neck Pain _____
- ☐ Osteoporosis _____
- ☐ Overactive Bladder _____
- ☐ Phlebitis/Thrombophlebitis _____
- ☐ Polyps _____
- ☐ Prostrate Disorder _____
- ☐ Psoriasis _____
- ☐ Recurrent Kidney Infection _____
- ☐ Rheumatoid Arthritis _____
- ☐ Rosacea _____
- ☐ Seizures _____
- ☐ Sexually Transmitted Diseases _____
- ☐ Sinusitis _____
- ☐ Stroke _____
- ☐ Surgically Sterilized _____
- ☐ Thyroid Issues _____

Patient Signature: _____

Date: _____

☐ Excessive Sweating (Hyperhidrosis) _____ ☐ Transient Ischemic Attack _____

☐ Fibromyalgia _____ ☐ Toe Nail Fungus _____

☐ Gastro esophageal Reflux (GERD) _____ ☐ Tuberculosis _____

☐ Glaucoma _____ ☐ Ulcerative Colitis _____

☐ Gout _____ ☐ Ulcers _____

☐ Heart Attack _____ ☐ Warts _____

☐ Heart Burn _____

☐ Heart Murmur _____ **Women Specifically:**

☐ Hemorrhoids _____ ☐ Began Taking Birth Control _____

☐ Hepatitis _____ ☐ Date of Last Menstrual Period _____

☐ High Blood Pressure _____ ☐ Endometriosis _____

☐ High Cholesterol _____ ☐ Gynecological Disorders _____

☐ History of Pneumonia _____ ☐ Hot Flashes _____

☐ Hiatal Hernia _____ ☐ Post-Menopausal Syndrome _____

☐ HIV/AIDS _____ ☐ Uterine Fibroids _____

Any other health issues? No [ ] Yes [ ] If yes, please explain _____

_____

Have you ever been in a research study? No [ ] Yes [ ] If yes, please explain when and where?
Are you currently involved in any litigation regarding a medical condition or injury? No [ ] Yes [ ]
If yes, please explain:
Did anyone in your family ever have: CANCER? ☐ HEART PROBLEMS? ☐ STROKE? ☐ DIABETES? ☐
If you have checked any of these, please explain:
Is there any other information you feel the doctor should know about you?

Patient Signature: _____

Date: _____