PATIENT INFORMATION FORM

All information given is strictly confidential

It is a pleasure to welcome you to our office. Please fill out all forms attached to aid us in preparing or updating your clinical records. All information given to us will be strictly confidential. Thank You.

DATE: _____ / _____/ _____

NAME: _____ _____ _____
First Middle Initial Last

ADDRESS: _____
Street City State Zip Code

HOME PHONE #: (_____) - _____ WORK PHONE # (_____) - _____

CELL PHONE # (_____) - _____ SSN _____-_____ -_____

SEX: Male or Female

HEIGHT: ___ /___ WEIGHT: ____ BIRTH DATE: _____ / ____ / _____
Feet / Inches Pounds

RACE: African-American ___ Caucasian ___ Asian ___ Other _____

ETHNICITY: Hispanic or Latino ____ Non-Hispanic or Latino _____

E-MAIL ADDRESS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

EDUCATION: ___High School ___College ___Graduate School ___GED ___Other: _____

PERSONAL CARE PHYSICIAN: _____ PHONE: _____

PHYSICIAN'S ADDRESS: _____
Street City State Zip Code

CHIEF COMPLAINT: _____

HOW DID YOU HEAR ABOUT US? _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE _____

LEGAL GUARDIAN OR CAREGIVER: _____

PHONE #: _____ CELL PH # _____ Best Time To Call _____

ADDRESS: _____
Street City State Zip Code

Eyes — **Date of Diagnosis**

- □ Cataracts _____
  - □ Left □ Right
- □ Glaucoma _____
  - □ Left □ Right
- □ Diabetic Retinopathy _____
  - □ Left □ Right
- □ Other: _____ _____

Ears, Nose, Throat — **Date of Diagnosis**

- □ Seasonal Allergies _____
- □ Other: _____ _____

Cardiovascular — **Date of Diagnosis**

- □ Chest Pain _____
- □ Heart Attack _____
- □ Fast Heart Rate _____
- □ Slow Heart Rate _____
- □ Irregular Heart Rate _____
- □ High Blood Pressure _____
- □ Swelling _____
  - □ Lower Extremities: □ Left □ Right
  - □ Upper Extremities: □ Left □ Right
- □ Blood Clots _____
  - Location: _____
- □ Cardiac Cath (Angioplasty) _____
  - Stenting: □ No □ Yes
- □ Coronary Artery Bypass Grafting _____
- □ Other: _____ _____

Musculoskeletal — **Date of Diagnosis**

- □ Osteoarthritis _____
- □ Rheumatoid Arthritis _____
- □ Psoriatic Arthritis _____
- □ Fibromyalgia _____
- □ Chronic Back Pain _____
  - Due to: _____
- □ Knee Replacement _____
  - L__ R__
- □ Other: _____ _____

Respiratory — **Date of Diagnosis**

- □ COPD _____
  - □ Last COPD Exacerbation _____
- □ Asthma _____
- □ Sleep Apnea _____
- □ Other: _____ _____

Gastrointestinal — **Date of Diagnosis**

- □ Indigestion _____
- □ Acid Reflux _____
- □ Hernia _____
  - □ Hiatal □ Femoral R / L □ Umbilical □ Incisional
  - □ Epigastric
- □ Chronic Diarrhea _____
- □ Chronic Constipation _____
- □ GI Bleeding _____
- □ Gall Stones _____
- □ Non-Functioning Gallbladder _____
- □ Pancreatitis _____
- □ Diverticulitis _____
- □ Other: _____ _____

Metabolic/Endocrine — **Date of Diagnosis**

- □ Elevated Cholesterol _____
- □ Elevated Lipids _____
- □ Elevated Triglycerides _____
- □ Diabetes Type: _____ _____
- □ Hypothyroidism (underactive) _____
- □ Hyperthyroidism (overactive) _____
- □ Potassium _____
  - High ____ Low_____
- □ Gout _____
  - Last flare: _____
- □ Anemia _____
- □ Vitamin Deficiency _____
  - Type: _____
- □ Other: _____ _____

Neurologic **Date of Diagnosis**

- □ Seizure _____
- □ Stroke _____
- □ TIA (mini stroke) _____
- □ Chronic Headaches/Migraines _____
- □ Neuropathy _____

  Hands: L__ R__ Feet: L__ R__
- □ Insomnia _____
- □ Alzheimer's _____
- □ Dementia _____
- □ Other: _____ _____

Genitourinary (Female) **Date of Diagnosis**

- □ Menopause _____
- □ Hysterectomy _____

  Full ___ Partial____ Due to: _____
- □ Overactive Bladder _____
- □ Other: _____ _____

Hepatobiliary **Date of Diagnosis**

- □ Liver Disease _____
- □ Hepatitis _____

  Type: _____
- □ Other: _____ _____

Cancer **Date of Diagnosis**

- □ Basal Cell Carcinoma _____

  Location: _____
- □ Squamous Cell Carcinoma _____

  Location: _____
- □ Other: _____ _____

Renal **Date of Diagnosis**

- □ Kidney Stones _____
- □ Kidney Disease _____
- □ Blood in urine _____
- □ Protein in urine _____
- □ Other: _____ _____

Psychiatric **Date of Diagnosis**

- □ Depression _____
- □ Anxiety _____
- □ ADHD/ADD _____
- □ Bipolar Disorder _____
- □ Suicidal Thoughts _____
- □ Suicide Attempts _____
- □ Other: _____ _____

Genitourinary (Male) **Date of Diagnosis**

- □ Enlarged Prostate _____
- □ Erectile Dysfunction _____
- □ Overactive Bladder _____
- □ Other: _____ _____

Dermatologic **Date of Diagnosis**

- □ Rashes _____
- □ Psoriasis _____
- □ Other: _____ _____

Additional Medical History	**Date of Diagnosis**

Form Completed By: _____ Date: _____

RA Updates Completed By: _____ Date: _____

CRC Updates Completed By: _____ Date: _____

PLEASE LIST ANY SURGERIES YOU HAVE EVER UNDERGONE:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

1. Do you use tobacco products? □ Present □ Past □ Never

Start Date: _____ Stop Date: _____

□ Cigarettes □ Cigars □ Pipe □ Chewing Tobacco

□ < ½ pack/day □ pack/day □ 1 ½ - 2 pack/day □ >2 pack/day

2. Do you use alcohol? □ Present □ Past □ Never

Start Date: _____ Stop Date: _____

□ Wine □ Beer □ Hard Liquor How much? _____

3. Have you ever used street drugs (Marijuana, Speed, Cocaine, Heroin, etc.)? □ Yes □ No

Drug: _____ Start Date: _____ Stop Date: _____

4. Do you have a history of falls? □ Yes □ No

Last fall date: _____ Start Date: _____

LIST ANY MEDICATION ALLERGIES AND THE SYPMTOMS YOU HAVE:

Medicine: _____ Symptoms: _____ Date: _____

Medicine: _____ Symptoms: _____ Date: _____

Medicine: _____ Symptoms: _____ Date: _____

Medicine: _____ Symptoms: _____ Date: _____

Medicine: _____ Symptoms: _____ Date: _____

Please list any medications the patient is **presently taking** or **have taken within the last 6 months**.
(Please include all vitamins, food supplements, herbal remedies, self-remedies, over-the-counter medications and prescriptions medications).

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Reason Taken

PLEASE ANSWER ALL QUESTIONS

1. I authorize Four Rivers Clinical Research, Inc., to leave a message on my answering machine regarding the appointment.

   Yes_____ No_____

2. May we leave a message with someone at your residence?

   Yes_____ No_____

   If yes, with whom should we leave the message regarding your appointment: _____

3. May we leave a message at any place other than your home?

   If yes, where: _____

   Who should we leave the message regarding your appointment with:

   _____

   Phone Number: _____

4. May we call you at work? ___Yes ___ No Phone # _____

5. May we leave a message at your work number? ___Yes ___No

6. May we send you text messages regarding current and upcoming studies? ___Yes ___No

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices from Four Rivers Clinical Research, Inc.

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE