Patient's Initials _____ _____ _____

Medical History Form

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Primary Care Doctor:** _____

This section is to be completed by office staff. ☐ **INFORMATION IS DOCUMENTED ON VISIT SOURCE**

Blood Pressure: _____ **Pulse:** _____ **Height:** _____ **Weight:** _____

Family History		
Does any 1st degree relative have cardiac disease?	☐ No	☐ Yes, describe:
Does any 1st degree relative have an autoimmune disorder?	☐ No	☐ Yes, describe:
Does any 1st degree relative have memory impairment?	☐ No	☐ Yes, describe:
Does any 1st degree relative have a history of cancer?	☐ No	☐ Yes, describe:

Allergies		
Any drug allergies? ☐ No ☐ Yes, type: ☐ No ☐ Yes, type: ☐ No ☐ Yes, type:	Start: Start: Start:	End: ☐ Ongoing End: ☐ Ongoing End: ☐ Ongoing
Any non-drug allergies? ☐ No ☐ Yes, type: ☐ No ☐ Yes, type: ☐ No ☐ Yes, type:	Start: Start: Start:	End: ☐ Ongoing End: ☐ Ongoing End: ☐ Ongoing
Any previous vaccine reactions? ☐ No ☐ Yes, type: ☐ No ☐ Yes, type: ☐ No ☐ Yes, type:	Start: Start: Start:	End: ☐ Ongoing End: ☐ Ongoing End: ☐ Ongoing

Patient's Initials _____ _____ _____

Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Gastrointestinal System				(Check box if ongoing)		
Acid Reflux	☐	☐		☐		☐ Yes
Colon Polyps	☐	☐		☐		☐ Yes
Colonoscopy (most recent)	☐	☐		N/A		☐ Yes
Constipation	☐	☐		☐		☐ Yes
Crohn's Disease	☐	☐		☐		☐ Yes
Diarrhea	☐	☐		☐		☐ Yes
Diverticulosis	☐	☐		☐		☐ Yes
Dyspepsia	☐	☐		☐		☐ Yes
Dysphasia	☐	☐		☐		☐ Yes
Gallstones	☐	☐		☐		☐ Yes
Gastroparesis	☐	☐		☐		☐ Yes
GERD	☐	☐		☐		☐ Yes
Heartburn	☐	☐		☐		☐ Yes
Indigestion	☐	☐		☐		☐ Yes
Irritable Bowel Syndrome	☐	☐		☐		☐ Yes
Pancreatitis	☐	☐		☐		☐ Yes
Ulcer	☐	☐		☐		☐ Yes
Ulcerative Colitis	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes

Patient's Initials _____ _____ _____

Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Hepatic / Liver				(Check box if ongoing)		
Alpha-1 Antitrypsin Deficiency	☐	☐		☐		☐ Yes
Cirrhosis	☐	☐		☐		☐ Yes
Fatty Liver Disease	☐	☐		☐		☐ Yes
Hemochromatosis	☐	☐		☐		☐ Yes
Hepatitis A	☐	☐		☐		☐ Yes
Hepatitis B	☐	☐		☐		☐ Yes
Hepatitis C	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Genitourinary				(Check box if ongoing)		
Endometriosis ☐ N/A	☐	☐		☐		☐ Yes
Fibroids ☐ N/A	☐	☐		☐		☐ Yes
Enlarged Prostate ☐ N/A	☐	☐		☐		☐ Yes
Erectile Dysfunction ☐ N/A	☐	☐		☐		☐ Yes
Kidney Disease	☐	☐		☐		☐ Yes
Kidney Stones	☐	☐		☐		☐ Yes
Low Libido / Sex Drive	☐	☐		☐		☐ Yes
Menopause	☐	☐		☐		☐ Yes
Urination Problems ☐ Difficulty Starting ☐ Frequent Urination ☐ Urinary Incontinence	☐	☐		☐		☐ Yes

Patient's Initials _____ _____ _____

Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Genitourinary Continued				(Check box if ongoing)		
Urinary Tract Infection	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Hematological				(Check box if ongoing)		
Anemia	☐	☐		☐		☐ Yes
Vitamin B12 Deficiency	☐	☐		☐		☐ Yes
Vitamin D Deficiency	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Eyes, Ears, Nose, & Throat:				(Check box if ongoing)		
Cataracts: ☐ Right ☐ Left ☐ Bilateral	☐	☐		☐		☐ Yes
Dry Eye	☐	☐		☐		☐ Yes
Farsighted	☐	☐		☐		☐ Yes
Nearsighted	☐	☐		☐		☐ Yes
Glaucoma	☐	☐		☐		☐ Yes
Hearing Loss	☐	☐		☐		☐ Yes
Macular Degeneration	☐	☐		☐		☐ Yes
Presbyopia	☐	☐		☐		☐ Yes
Retinopathy	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes

Patient's Initials _____ _____ _____

Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Neurological				(Check box if ongoing)		
Carpal Tunnel Syndrome ☐ Right ☐ Left ☐ Bilateral	☐	☐		☐		☐ Yes
Head Injury	☐	☐		☐		☐ Yes
Headaches	☐	☐		☐		☐ Yes
Memory Loss: ☐ Dementia ☐ Alzheimer's ☐ Age Related	☐	☐		☐		☐ Yes
Migraines	☐	☐		☐		☐ Yes
Mini-Stroke (TIA)	☐	☐		☐		☐ Yes
Sciatica	☐	☐		☐		☐ Yes
Seizures	☐	☐		☐		☐ Yes
Stroke	☐	☐		☐		☐ Yes
Tremors	☐	☐		☐		☐ Yes
Vertigo	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Respiratory				(Check box if ongoing)		
Asthma	☐	☐		☐		☐ Yes
COPD	☐	☐		☐		☐ Yes
COVID-19	☐	☐		☐		☐ Yes
Cystic Fibrosis	☐	☐		☐		☐ Yes
Emphysema	☐	☐		☐		☐ Yes

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Respiratory Continued				(Check box if ongoing)		
Supplemental Oxygen Use	☐	☐		☐		☐ Yes
Seasonal Allergies	☐	☐		☐		☐ Yes
Sleep Apnea	☐	☐		☐	CPAP Compliant? ☐ Yes ☐ No ☐ N/A	☐ Yes
Other:				☐		☐ Yes
Dermatology				(Check box if ongoing)		
Acne	☐	☐		☐		☐ Yes
Eczema	☐	☐		☐		☐ Yes
Fungus: Location:	☐	☐		☐		☐ Yes
Psoriasis	☐	☐		☐		☐ Yes
Rashes	☐	☐		☐		☐ Yes
Rosacea	☐	☐		☐		☐ Yes
Skin Cancer (Basal)	☐	☐		☐		☐ Yes
Skin Cancer (Melanoma)	☐	☐		☐		☐ Yes
Skin Cancer (Squamous)	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Musculoskeletal				(Check box if ongoing)		
Arthritis: Osteoarthritis	☐	☐		☐		☐ Yes
Arthritis: Psoriatic	☐	☐		☐		☐ Yes
Arthritis: Rheumatoid	☐	☐		☐		☐ Yes
Back Pain	☐	☐		☐		☐ Yes

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Musculoskeletal Continued				(Check box if ongoing)		
Bone Injuries	☐	☐		☐		☐ Yes
Fibromyalgia	☐	☐		☐		☐ Yes
Gout	☐	☐		☐		☐ Yes
Muscle Spasms	☐	☐		☐		☐ Yes
Muscular Dystrophy	☐	☐		☐		☐ Yes
Osteopenia	☐	☐		☐		☐ Yes
Osteoporosis	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Endocrine / Metabolic				(Check box if ongoing)		
Diabetes Type 1	☐	☐		☐		☐ Yes
Diabetes Type 2	☐	☐		☐		☐ Yes
Diabetic Neuropathy	☐	☐		☐		☐ Yes
High Cholesterol	☐	☐		☐		☐ Yes
High Triglycerides	☐	☐		☐		☐ Yes
Hyperthyroidism	☐	☐		☐		☐ Yes
Hypothyroidism	☐	☐		☐		☐ Yes
Overweight	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Neoplasia				(Check box if ongoing)		
Cancer:	☐	☐		☐		☐ Yes
Other:	☐	☐		☐		☐ Yes

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Cardiovascular				(Check box if ongoing)		
A-Fib	☐	☐		☐		☐ Yes
Carotid Artery Disease	☐	☐		☐		☐ Yes
Chest Pain	☐	☐		☐		☐ Yes
Coronary Artery Disease	☐	☐		☐		☐ Yes
Defibrillator	☐	☐		☐		☐ Yes
Heart Attack	☐	☐		☐		☐ Yes
Heart Catheter	☐	☐		☐		☐ Yes
Heart Failure	☐	☐		☐		☐ Yes
High Blood Pressure	☐	☐		☐		☐ Yes
Irregular Heart Beats	☐	☐		☐		☐ Yes
Pacemaker	☐	☐		☐		☐ Yes
Peripheral Artery Disease	☐	☐		☐		☐ Yes
Peripheral Vascular Disease	☐	☐		☐		☐ Yes
Poor Circulation in Legs	☐	☐		☐		☐ Yes
Statin Intolerant	☐	☐		☐		☐ Yes
Stent	☐	☐		☐		☐ Yes
Swelling in Legs or Feet ☐ Right Foot ☐ Left Foot ☐ Right Leg ☐ Left Leg ☐ Chronic ***or*** ☐ Intermittent	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes

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Infectious Disease				(Check box if ongoing)		
C. Diff	☐	☐		☐		☐ Yes
HIV	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Autoimmune Disease				(Check box if ongoing)		
Celiac Disease	☐	☐		☐		☐ Yes
Lupus	☐	☐		☐		☐ Yes
Multiple Sclerosis	☐	☐		☐		☐ Yes
Sjogren's Syndrome	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes
Psychiatric				(Check box if ongoing)		
Anxiety	☐	☐		☐		☐ Yes
Attention Deficit Disorder (ADD)	☐	☐		☐		☐ Yes
Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐		☐		☐ Yes
Bipolar Disorder	☐	☐		☐		☐ Yes
Depression	☐	☐		☐		☐ Yes
Insomnia	☐	☐		☐		☐ Yes
Schizophrenia	☐	☐		☐		☐ Yes
Other:				☐		☐ Yes

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Vaccination History			
COVID-19 *(Most Recent)* **Date:**	**Type:**	**Prior COVID-19 Vaccinations?** ☐ Yes ☐ No	☐ N/A
Flu *(Most Recent)* **Date:**	☐ N/A	**Tetanus** ***(if in past 12 months)*** **Date:**	☐ N/A
Shingles Dose 1: **Dose 2:**	☐ N/A	**Pneumonia Dose 1:** **Dose 2:**	☐ N/A

Personal Habits	
Do you have a history of tobacco use? ☐ Current ☐ Former ☐ Never	**Type (If applicable):** ☐ Cigarettes ☐ Cigars ☐ Smokeless ☐ Pipe ☐ Vape
Smoking Start Date: _____ **Amount Smoked/Day:** _____ **Smoking End Date:** _____	
Do you have a history of recreational drug use? ☐ Current ☐ Current, with prescription ☐ Former ☐ Never	
Do you have a history of alcohol abuse? ☐ Current ☐ Former, length of sobriety: _____ ☐ Never	
On average, how many alcoholic drinks do you consume weekly?	

For Women Only	
Can you still have children? ☐ Yes, list birth control_____ ☐ No, reason: ☐ Post-menopausal ☐ Hysterectomy ☐ Ovaries removed	
Last Mammogram:	**Last Well-Woman Exam:**

Patient Signature: _____ Date: _____

Study Coordinator Signature: _____ Date: _____

Clinically Significant for EDC ☐ N/A
***Only use this column on medical history for protocols that specify clinically significant medical history for data entry.
Investigator Signature of Clinical Significance[#] Review, if required: **Signature:** **Date:**
[#]Items marked "YES" in the clinically significant column should be entered into EDC based on investigator judgment and protocol-specific requirements.