Essential Medical Research, LLC
4765 E 91st Street, Suite 200
Tulsa, OK 74137

Confidential Subject Information

Patient ID # *(if DFDG pt)*		**SSN**		**Race/ Ethnicity**	□ White □ Black □ Asian □Other_____	**□ Hispanic □ Non-Hispanic**	
First Name		**M.I.**		**Last Name**			
Nickname		**D.O.B**		**Marital Status**	□ Single □ Married □ Divorced □ Widowed	**Sex**	□ M □ F
Address							
City		**State**		**Zip Code**			
Home Phone				**Cell Phone**			
Work/Other Phone				**Email**			
Best way to contact you?	□ Home □ Cell □ Work/Other □ Email			**Best time to contact you?**			
How did you hear about us?		**Prior Study Experience**		□ Yes □ No Exclusionary? □ Yes □ No			

Physician Information

Primary Care Physician		**Referring Physician** (if applicable)	
Address			
City/State/Zip		**Phone**	

Parent or Legal Guardian (if patient is under 18) Information

First Name		**M.I.**		**Last Name**	
Relationship to Subject		**D.O.B**		**SSN**	
Address					
City		**State**		**Zip Code**	
Home Phone			**Cell Phone**		

Insurance Information

(In order for compensation, answer is required)

Is the research participant a Medicare beneficiary?	□	**Yes**	□	**No**

Emergency / Information Contact

Name		**Phone Number**	

Thank you for participating in our clinical studies!

May we send you appointment reminder texts to your phone? □ Yes □ No

May we contact you for future studies including email? □ Yes □ No

□ I acknowledge a receipt of a copy of Notice of Privacy Practices.

□ I give consent and authorization for the staff of the Clinical Research office to leave Protected Health Care Information about me or for me on my answering machine or voicemail via the telephone number I have listed. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Date		**Subject Signature** (Parent/Legal Guardian if applicable)	

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Protocol:_____ Subject #:_____ Initials:_____ Date:_____

SELF REPORTED PERSONAL MEDICAL HISTORY

PLEASE LIST ALL MEDICAL CONDITIONS INCLUDING DATE OF DIAGNOSIS:

Yes	No		Date
		Cardiovascular	
☐	☐	High Blood Pressure	_____
☐	☐	High Cholesterol	_____
☐	☐	Congestive Heart Failure	_____
☐	☐	Heart Attack	_____
☐	☐	Irregular Heart Rhythm	_____
☐	☐	Heart Valve Disease/ Replacement	_____
☐	☐	Defibrillator / Pacemaker	_____
		Pulmonary	
☐	☐	Asthma	_____
☐	☐	Emphysema	_____
☐	☐	Tuberculosis	_____
☐	☐	COPD	_____
		Renal/Kidney	
☐	☐	Renal Insufficiency	_____
☐	☐	Dialysis	_____
☐	☐	Kidney Stones	_____
		Liver/Gastrointestinal	
☐	☐	Hepatitis	_____
☐	☐	Cirrhosis	_____
☐	☐	Gall Stones	_____
☐	☐	Peptic Ulcers	_____
☐	☐	Ulcerative Colitis	_____
☐	☐	Irritable Bowel syndrome	_____
☐	☐	GERD	_____
☐	☐	Crohn's disease	_____
		Skin	
☐	☐	Psoriasis	_____
☐	☐	Acne	_____
☐	☐	Rosacea	_____
☐	☐	Atopic Dermatitis/Eczema	_____

Yes	No		Date
		Eye	
☐	☐	Cataracts	_____
☐	☐	Glaucoma	_____
		Neurologic/Psychiatric	
☐	☐	Seizures/Epilepsy	_____
☐	☐	Stroke	_____
☐	☐	Migraines	_____
☐	☐	Depression	_____
☐	☐	Anxiety	_____
☐	☐	Suicide attempt	_____
		Endocrine	
☐	☐	Hypothyroid	_____
☐	☐	Hyperthyroid	_____
☐	☐	Diabetes Type I	_____
☐	☐	Diabetes Type II	_____
		Musculoskeletal	
☐	☐	Osteoporosis	_____
☐	☐	Rheumatoid Arthritis	_____
☐	☐	Psoriatic Arthritis	_____
☐	☐	Osteoarthritis	_____
		General	
☐	☐	Insomnia	_____
☐	☐	AIDS/HIV+	_____
☐	☐	Hepatitis B or C	_____
☐	☐	Gout	_____
☐	☐	Seasonal Allergies	_____

☐ ☐ **History of Cancer** (Type):_____

		Females				**Males**
☐	☐	Postmenopausal x 2 yrs	_____	☐	☐	Vasectomy _____
☐	☐	Surgically Sterile	_____	☐	☐	Partner post menopause _____
☐	☐	Birth Control	_____	☐	☐	Partner Surgically sterile _____

Contraception Method:_____

Alcohol Use: ☐ Yes ☐ No If Yes: How many drinks _____ Per Week / Month/Year How Long:_____
What type: ☐ Beer ☐ Wine ☐ Liquor

Tobacco Use: ☐ Yes ☐ No If Yes: How many ____ Per Day / Week How Long:_____
What type: ☐ Cigarettes ☐ Cigars ☐ Pipe

Any other medical history not previously addressed:

_____

_____

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Protocol:_____ Subject #:_____ Initials:_____ Date:_____

PREVIOUS SURGERIES:

Name of Surgery:	**Date:**	**Reason:**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

MEDICATIONS (Including all over the counter medications, vitamins and supplements)

Medication Name:	Dosage:	Reason taken:	Start Date:
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____
10. _____	_____	_____	_____

ALLERGIES TO MEDICATIONS:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

_____ _____ _____ _____

Patient Signature Date Coordinator Signature Date

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