International Clinical Research – US, LLC (IC Research)
PATIENT 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)** ________
☐ **Fibromyalgia** ____________________________
☐ **Gastro esophageal Reflux (GERD)** _________
☐ **Glaucoma** _______________________________
☐ **Gout** ___________________________________
☐ **Heart Attack** ____________________________
☐ **Heart Burn** ______________________________
☐ **Heart Murmur** ____________________________
☐ **Hemorrhoids** _____________________________
☐ **Hepatitis** _______________________________
☐ **High Blood Pressure** ______________________
☐ **High Cholesterol** _________________________
☐ **History of Pneumonia** _____________________
☐ **Hiatal Hernia** ____________________________
☐ **HIV/AIDS** ________________________________

☐ **Transient Ischemic Attack** ________________________
☐ **Toe Nail Fungus** _________________________________
☐ **Tuberculosis** ____________________________________
☐ **Ulcerative Colitis** _______________________________
☐ **Ulcers** ____
☐ **Warts** ____

Women Specifically:

☐ **Began Taking Birth Control** ____________________
☐ **Date of Last Menstrual Period** __________________
☐ **Endometriosis** __________________________________
☐ **Gynecological Disorders** _________________________
☐ **Hot Flashes** ____________________________________
☐ **Post-Menopausal Syndrome** _____________________
☐ **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:____