International Clinical Research – US, 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)** ________

☐ **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:____