WestVirginiaUniversity.

CPRC Clinical & Pharmacologic Research Center

Volunteer ID (Office Use Only):

MEDICAL HISTORY FORM COUNSELING CONFIRMATION

VOLUNTEER INSTRUCTIONS:

- **DO NOT COMPLETE THIS PAGE (page 1) AT HOME - Bring it with you to the clinic.**

WVU CPRC STAFF INSTRUCTIONS:

- Complete this form ONLY when you have reviewed the entire medical history form with the volunteer.
- Upon a full review and confirmation of understanding of all sections of the medical history form, the WVU CPRC clinical staff member, the volunteer and a witness must sign and date the form.

CONTRACEPTIVE COUNSELING CONFIRMATION

The **Volunteer** agreed to use the following methods for the prevention of pregnancy:

☐ Birth-control Pills (*females only*)	☐ Nuvaring	☐ Same-sex partner
☐ Essure	☐ Subdermal (norplant)	(Male:Male or Female:Female)
☐ IUD-Copper	☐ Tubal ligation	☐ Abstinence
☐ IUD-hormonal	☐ Vasectomy	☐ Other: _____
	☐ Barrier (foam, condom, diapragm)	

By signing below, the volunteer acknowledges they have been counseled on and agree to use the method(s) of contraception checked above:

_____ _____

Volunteer *Date*

_____ _____

WVU CPRC Clinical Staff *Date*

SIGNATURES

I understand that by giving false, incomplete, or misleading information about my medical history could have very serious consequences, The information on the medical history form is accurate to the best of my knowledge.

_____ _____

Volunteer *Date*

_____ _____

Witnessed by: *Date*

_____ _____

Reviewed by: (this review is inclusive of all past medical history) *Date*

☐ Check this box if form was not completed at time of visit.

Reason form was not completed: ☐ Screen Failure ☐ Withdrew Consent ☐ Other:

OFFICE USE ONLY
(□ N/A if initial MHF)
This MHF has been reviewed against all prior history forms and is confirmed to be an all-inclusive review

1st Review Initials / Date: _____ / _____

QC Review Initials / Date: _____ / _____

OFFICE USE ONLY
ID/Age Verified by:

_____

initials / date

Volunteer ID (Office Use Only):

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MEDICAL HISTORY FORM

GENERAL INSTRUCTIONS:

- To protect your safety, it is **critical** that all information be complete and accurate.
- Please read the instructions for each section to ensure you are completing the form correctly.
- If printing the form, please print all information clearly and carefully using **BLUE OR BLACK** ink only.
- **DO NOT** erase, white out or write over errors. If a mistake is made, please draw a single line through the error, write the correct entry nearby and initial and date the correction.
- Please **initial and date** the bottom of pages 2-10 as you complete each page.
- **BRING the entire form (pages 1-10) to the clinic with you on the day of your appointment.**

SECTION A: IDENTIFICATION

Instructions: *Please print first name, middle initial and last name exactly as they appear on your identification (e.g. driver's license, passport, etc…)*

First Name:	**MI:**	**Last Name:**
Date of Birth:	**Age:**	**Social Security #:** __ __ __-__ __-__ __ __ __
Phone #: ( ) __ __ __ -__ __ __ __	**Alternate Phone #: ( ) __ __ __ -__ __ __ __**	
Permanent Mailing Address (address where you receive your tax statement and where checks less than $50.00 will be mailed).	**Street:**	
	City:	
	State:	**Zip:**
Local Address (if different from permanent address):	**Street:**	
	City:	
	State:	**Zip:**
Do you work? No ☐ Yes ☐ If yes, please complete →	**Job Title:**	**Normal Work Hours:**
Are you a WVU Medical student?: No ☐ Yes ☐		
Emergency Contact Information: **Name:**	**Phone #: ( ) __ __ __ -__ __ __ __**	**Relationship:**
Primary Care Physician: ☐ **N/A**	**Name:**	**Phone #: ( ) __ __ __ -__ __ __ __**

SECTION B: DEMOGRAPHICS

Instructions: *Please mark only one area in the race section. If you are biracial and would like to indicate this, please mark "other" and fill in the blank.*

Sex	☐ Male	☐ Female
Ethnicity	☐ Hispanic or Latino	☐ Not Hispanic or Latino
Race	☐ White	☐ Black or African American
	☐ Asian	☐ American Indian or Alaska Native
	☐ Native Hawaiian or Other Pacific Islander	☐ Other: _____

_____ / _____
initials / *date*

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MEDICAL HISTORY FORM

SECTION C: SURGICAL HISTORY		
Instructions: *Please provide as much information as possible about the surgery. If the procedure was done within the last year, please provide the exact date.* ***If none, please check box and continue to section D.*** ☐		
NAME OF SURGERY/WHAT WAS DONE	**YEAR**	**WHY WAS IT DONE (REASON)**

SECTION D: HOSPITALIZATIONS		
Instructions: *Please only list hospitalizations which involved an overnight stay. If hospitalization was within the last year, please provide exact date.* ***If none, please check box and continue to Section E.*** ☐		
REASON FOR HOSPITALIZATION	**YEAR**	**EXPLANATION** (N/A if self-explanatory)

_____ /
initials / *date*

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MEDICAL HISTORY FORM

SECTION E: MEDICAL ILLNESSES						
Instructions: *A medical illness refers only to you, not family history. Please read section descriptions and answer yes to sections that apply to you.* ***Circle the specific condition*** *you had and document date of onset. If condition occurred within the last year, please record the month, day, and year the condition occurred. If condition occurred greater than a year ago, listing just the year is sufficient. If you have a condition that is not listed, please inform the staff so information can be documented appropriately.*						
SYSTEM	**DISORDER or SYMPTOM**	**NO**	**YES**	**DATE OF ONSET**	**DESCRIBE**	**PHYSICIAN ONLY**
GENERAL	Fever, Chills, Drenching night sweats, Pruritus (itching), Fatigue, Malaise, Change in weight, Change in appetite					
SKIN	Acne, Boils, Shingles, Rash, Ulcers, Dry hair or skin, Masses, Moles (change or bleeding), Jaundice, Skin cancer, Psoriasis, Eczema					
BLOOD SYSTEM / VEINS	Anemia, Swollen Lymph nodes, Blood diseases, Leukemia/lymphoma, Bleeding problems, Blood clots, Past use of blood thinners, Bruising					
HEAD	Headache/migraines, Other head pain, Trauma, Skull fracture					
EYE	Visual changes, Pain, Infection, Glaucoma (Increased eye pressure), Tearing, Dry eyes, Double vision, Loss of peripheral vision, Discharge (conjunctivitis), Red eyes, Angioedema					
EAR	Decreased hearing, Tinnitus (Ringing), Discharge, Infection, Balance disorder, Veritgo, Pain					
NOSE	Nosebleeds, Runny nose/discharge, Sinusitis, Changes in smell, Nasal polyps					
MOUTH / THROAT	Dental problems, Tongue problems, Change in taste, Mouth lesions or ulcers, Dentures, Dry mouth, Bleeding (mouth or gums), Gum disease, Caries, TM joint problems, Difficulty swallowing, Hoarseness, Tonsillitis					
LUNG / RESPIRATORY	Shortness of breath at rest or with exertion, Change in exercise tolerance, Asthma, COPD, TB or exposure to tuberculosis, Pneumonia, Bronchitis, Wheezing, Cough (productive or nonproductive, blood), Chest tightness, Pulmonary embolus, Excessive snoring, Sleep apnea, Any abnormal chest X-ray in past, Positive PPD or prior BCG					

_____ / _____
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SYSTEM	DISORDER or SYMPTOM	NO	YES	DATE OF ONSET	DESCRIBE	PHYSICIAN ONLY
IMMUNE	Hay fever, Sneezing, Immune deficiencies, Desensitization treatments (Allergy shots), Other allergies not mentioned in separate allergy section, Anaphylaxis, Autoimmune disorders (Lupus, Rheumatoid Arthritis), HIV / AIDS					
HEART	High blood pressure, Chest pain, Heart attack, Murmur or valve lesion, Catheterization/bypass/angioplasty, PVCs/Afib/Other rhythm problems or palpitations, Dizziness, Syncope (passing out) or near-syncope, Loss of consciousness, Antibiotics before dental procedures, Swelling, Abnormal EKG, low blood pressure, orthostatic hypotension					
PERIPHERAL VASCULAR	Blood clots, Muscle pain when walking, Blue discoloration of skin, Thrombophlebitis, Vein problems or varicose veins, Cold feet, Ulcers, fluid retention (edema)					
GASTRO-INTESTINAL	Abdominal Pain, Nausea/vomiting, Heartburn, Ulcer, Change in bowel habits, Diarrhea or constipation, Black stools, Bright red blood from rectum, History of polyps, Family history of polyps/cancer, Pancreatitis, Gall bladder disease, Gallstones, Appendicitis, Prior abdominal surgery/adhesions, Irritable bowel syndrome (IBS), Inflammatory bowel disease (IBD), Hepatitis, Hernias, Hemorrhoids, Other liver disease					
REPRODUCTIVE (MALE) ☐ N/A	Decreased libido, Sexual difficulties, Erectile dysfunction, Painful intercourse, Infertility issues, Penile discharge, Penile lesions, Testicular pain or masses, Enlarged prostate					
REPRODUCTIVE (FEMALE) ☐ N/A	Decreased libido, Sexual difficulties, Painful intercourse, Infertility issues, Vaginal infections, Pelvic Inflammatory Disease (PID), Irregular menses, absent menses, painful menses, Vaginal discharge or discomfort, Pregnancy loss, Abnormal Pap test					

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SYSTEM	DISORDER or SYMPTOM	NO	YES	DATE OF ONSET	DESCRIBE	PHYSICIAN ONLY
ENDOCRINE	Thyroid problems (Hypothyroid, myxedema or other), Heat or cold intolerance, Hot flashes, Diabetes, Excess thirst or urination, Fractures, Osteoporosis, Loss of height, High Cholesterol or Triglycerides, Adrenal insufficiency					
KIDNEY / URINARY	Kidney stones, Kidney infections, Urinary tract infection (UTI), Urgency, Frequent urination, Burning, flank pain, Bladder pain, Blood in urine, Foamy urine, Urethral stricture, Incontinence (trouble controlling urine)					
BREAST	Masses or lumps, discharge, Pain, Change in nipples, Abnormal Mammogram					
BONE OR MUSCLE DISORDER	Joint inflammation (pain, redness, swelling, warmth, deformity), Arthritis, Morning stiffness, Joint injuries, Limb problems (swelling, redness, warmth, or tenderness), Muscle pain or weakness, Back pain, Neck pain					
NEUROLOGIC	Seizures or epilepsy, Stroke, Dizziness or vertigo, Tremor, Involuntary movements, Gait problems, Numbness or tingling, Cognitive or memory concerns, Narcolepsy, falling asleep without warning					
EMOTIONAL / PSYCHIATRIC	Depressive symptoms (e.g., feeling down or blue, crying, loss of interest in friends, etc.), Anxious, Worries or fears, Phobias, OCD behaviors, ADD/ADHD behaviors, panic attacks, Hallucinations (visual/auditory), Suicidal/homicidal thoughts, Insomnia					
ANY OTHER MEDICAL CONDITIONS						
Additional Comments:						

_____ / _____
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MEDICAL HISTORY FORM

SECTION F: MEDICATION HISTORY

Instructions: *Please list every medication taken within the last* ***30 days*** *including prescription and over-the-counter medications, immunizations or allergy shots, as well as any vitamins, supplements or herbs. If (non-Hormonal) depot (time released) injections of medication, please list last 3 months.*

If none, please check box and move to section G. ☐

DRUG NAME	DOSE	UNIT	ROUTE	START DATE	STOP DATE	FREQUENCY (how many times)	REASON FOR USE
(e.g. Tylenol)	650	mg	Oral	July 7, 2013	July 22, 2013	1 per day, week, etc.	Headache

SECTION G: HORMONE THERAPY

Instructions: *Please list any hormones taken in the last three months (e.g. birth control, estrogen, depot injection, hormone creams, testosterone etc…)* ***If none, please check box and move to section H.*** ☐

DRUG NAME	DOSE	UNIT	ROUTE	START DATE	STOP DATE	FREQUENCY (how many times)	REASON FOR USE

SECTION H: MISCELLANEOUS

Instructions: *Only record if you have donated blood at a blood donation center, or lost a large amount of blood (like from an accident). Blood taken at a doctor's visit will not need to be documented. If you answer YES to this question, please provide date and where blood was collected.*

QUESTION	NO	YES	If YES, please complete
Have you donated blood, plasma, or other blood products or had loss of blood within the past 60 days.			**Date:** **Where:**
Have you ever participated in a study with us (WVU CPRC)?			
Have you participated in an investigational drug study in the last 30 days?			**Date:** **Where:**
Do you have a recent history (less than 6 months) of travel to, or move from, any country outside the United States?			**Date:** **Travel location:**
Have you had any contact with someone known to have active tuberculosis?			**When:**
Do you have a criminal record/history? (e.g. bond, indictment, imprisonment, probation, house arrest, etc.)			Office use only Volunteer Background Record obtained Yes ☐ No ☐

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MEDICAL HISTORY FORM

SECTION I: ALLERGIES			
Instructions: *Please include all allergies and sensitivities to medications, foods, adhesive tape or the environment.* ***If none, please check box and move to section J.*** ☐			
NAME	**DATE DIAGNOSED**	**DATE OF LAST REACTION**	**DESCRIBE REACTION**
Ex. Amoxicillin	July 2004	October 15, 2013	Hives

SECTION J: FAMILY HISTORY	
Instructions: *Please include any illnesses that runs in the family; specify the relationship (Examples include: diabetes, high blood pressure, high cholesterol, heart disease, anemia, bleeding disorders, cancers, colitis, hepatitis, cirrhosis, kidney disorders, osteoporosis, stroke, mental disability, alcoholism, arthritis, etc.)* ***If none or unknown, please check box and move to section K.*** ☐ ***None*** ☐ ***Unknown***	
FAMILY ILLNESS	**RELATIONSHIP**

_____ /
initials / *date*

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MEDICAL HISTORY FORM

SECTION K: HEALTH HABITS AND PERSONAL SAFETY

Instructions: *Please review each of the following sections and complete each section according to your lifestyle, needs and preventative measures.*

EXERCISE:

- ☐ No exercise (sedentary)
- ☐ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e. work or recreation, less than 4 x's per week for 30 minutes)
- ☐ Regular vigorous exercise (i.e. work or recreation, 4 x / week for 30 minutes or more)

DIET:

Are you currently on a diet? ☐ No ☐ Yes

→ **If yes,** is your diet prescribed by a physician? ☐ No ☐ Yes

Are you lactose intolerant? ☐ No ☐ Yes

Do you have any other food allergies, restrictions or special diet? ☐ No ☐ Yes → **If yes,** please describe:

_____

_____

1. CAFFEINE

Instructions: *Please select each type of caffeine you drink and indicate* ***how much*** *(cups/cans) and* ***how often*** *(daily, weekly, monthly) you drink it.* ***If you do not drink caffeine, please check the box and move to number 2.*** ☐

☐ **COFFEE**	☐ **TEA**	☐ **COLA**	☐ **OTHER** _____
If checked, please tell us	If checked, please tell us	If checked, please tell us	If checked, please tell us
How much: _____	How much: _____	How much: _____	How much: _____
How often: _____	How often: _____	How often: _____	How often: _____

2. ALCOHOL

Instructions: *Please select each type of alcohol you drink and indicate* ***how much*** *(cups/cans) and* ***how often*** *(daily, weekly, monthly) you drink it.* ***If you do not drink alcohol, please check the box and move to number 3.*** ☐

☐ **BEER**	☐ **WINE**	☐ **LIQUOR**	☐ **OTHER** _____
If checked, please tell us	If checked, please tell us	If checked, please tell us	If checked, please tell us
How much: _____	How much: _____	How much: _____	How much: _____
How often: _____	How often: _____	How often: _____	How often: _____

_____ / _____
initials / *date*

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MEDICAL HISTORY FORM

3. TOBACCO

Instructions: *Please select each type of tobacco product you use, how often you use it and for how many years you have used it.*

☐ **CIGARETTES**	☐ **CHEW/SNUFF**	☐ **PIPE**	☐ **CIGAR**
If checked, please tell us	If checked, please tell us	If checked, please tell us	If checked, please tell us
Pack/day: _____	#/day: _____	#/day: _____	#/day: _____
Years: _____	Years: _____	Years: _____	Years: _____

Have you ever smoked or used a tobacco product? ☐ No ☐ Yes → **If yes,** please answer the following:

What kind of tobacco product: _____

Amount used: _____

When did you quit: _____

If you do not use tobacco products, please check the box. ☐

4. DRUGS

Instructions: *Please indicate whether you use or have used recreational (street) drugs. If you answer yes to either of the questions, please explain.*

Do you currently use recreational or street drugs? ☐ No ☐ Yes → If yes, please explain:

_____

Do you have a history of drug use or abuse? ☐ No ☐ Yes → If yes, please explain:

5. PREGNANCY PREVENTION

Instructions: *What type of birth control method are you and your partner currently using? You may select more than one choice.*

If you are not sexually active (e.g. abstinent and not having sex), please check the box. ☐

☐ Same-sex partner (Male:Male or Female:Female)
☐ Vasectomy
☐ Nuvaring
☐ Birth-control Pills
☐ IUD-Copper
☐ Subdermal (norplant)
☐ Tubal ligation
☐ IUD-hormonal
☐ Other _____
☐ Essure
☐ Barrier (foam, condom, diaphragm)

How long have you been using the birth control method(s) that you indicated above?

_____

_____ / _____
initials / *date*

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WOMEN ONLY		
Instructions: *The remaining sections pertain only to women, Please indicate if you have had or have a family history of the following disorders and specify in the blank provided.*		
DISORDER	NO	YES
Reproductive Cancer (Uterine, Cervical, Ovarian) If yes please list: _____		
Endometrial Hyperplasia - If yes, Please explain: _____		
Breast Cancer (include family genetic link i.e.maternal/paternal) If yes, please explain: _____		
MENSTRUAL HISTORY		
Instructions: *Please indicate if you are pre-menopausal or post-menopausal and answer the questions* accordingly.		
MENSTRUAL STATUS	NO	YES
First Day of Last Menstrual Period? Date: _____	Not Applicable	
Have you had any vaginal bleeding since your last menstrual period? If yes, when: _____		
Please answer the following questions:	NO	YES
Postmenopausal without vaginal bleeding for at least one (1) year. (Still have a uterus and ovaries)		
Oophorectomy (removal of one or both ovaries) ☐ one ☐ both		
Total hysterectomy (removal of uterus and cervix)		
Partial (or sub-total) hysterectomy (removal of uterus but not the cervix)		

OFFICE USE ONLY	NO	YES
Is the volunteer of childbearing potential? (WOMEN ONLY)		

_____ / _____
initials / *date*