Volunteer Information & Medical History Form PLEASE PRINT

Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other_____

Last Name First Name Initial

Address City State Zip Code

( ) ( )
Daytime Telephone Evening Telephone Occupation

Education Level: ☐ Grade School ☐ High School ☐ College ☐ Post Grad ☐ Other

Date of Birth _____/_____/_____ Age_____
month day year

Sex: ☐ Male ☐ Female Race: ☐ Asian ☐ Hispanic ☐ White

Height:_____ Weight:_____ ☐ Black ☐ Native American ☐ Other_____

SMOKING HISTORY

Never Smoked Previous Smoker, Quit: ____/____/____ Amount/Day_____ Yrs_____

Current Smoker Amount/Day_____ Yrs_____

ALCOHOL USE

Amount of alcohol is defined as follows:

12 oz. Regular or lite beer = 1 drink 4 oz. wine = 1 drink
2 oz. desert wine = 1 drink 1 oz. spirits = 1 drink

How many alcoholic beverages do you drink per week (average)?_____

CURRENT SPECIAL DIETS FOLLOWED

Diabetic Low-fat/Low-cholesterol Other:_____

Low-salt Weight reduction _____

Volunteer Information & Medical History

Please fill in "DATE BEGUN", "DATE ENDED" and "CONDITION CONTINUES?" for all "YES" answers.

CARDIOVASCULAR (Heart & Circulation)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Blood Clots						
Hypertension (high blood pressure)						
MI (heart attack)						
Coronary (heart) Artery Disease						
Carotid Artery Disease (blocked neck arteries)						
Claudication (blocked leg arteries)						
Angina (chest pain)						
Arrhythmia (irregular heart beats)						
Palpitation						
Congestive Heart Failure (enlarged heart)						
Endocarditis (heart muscle inflammation)						
Peripheral Vascular Disease						
Leg-Swelling (Edema)						
Other (describe)_____						

GASTROINTESTINAL (Stomach & Intestines)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Esophageal Reflux						
Indigestion						
Diarrhea (frequent)						
Constipation (frequent)						
Hiatal Hernia						
Ulcer						
Gallbladder Disease						
Gallstones						
Diverticulitis/Diverticulosis (Polyps)						
Hemorrhoids						
Other (describe):_____						

MUSCULOSKELETAL (Muscles & Bones)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Arthritis						
Back Problem (specify):						
Fractures, broken bones / specify which bones:						
Other (describe):						

EYES

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Glasses or Contact Lenses						
Cataracts						
Glaucoma						
Diabetic Retinopathy						
Other (describe):						

EARS

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Hearing Loss						
Balance Problems						
Other (describe):						

NOSE / MOUTH / THROAT

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Sinus Congestion (frequent)						
Other (describe):						

RESPIRATORY

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Asthma						
Bronchitis						
Emphysema						
Pneumonia						
Tuberculosis						
Other (describe)						

DERMATOLOTICAL

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ECZEMA (SEVERE DRY SKIN)						
LEG OR FOOT ULCERS						
OTHER (DESCRIBE)						

PSYCHOSOCIAL (BEHAVIOR)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ALCOHOLISM						
RECREATIONAL DRUGS						
DEPRESSION						
ANXIETY OR PANIC DISORDERS						
INSOMNIA						
EATING DISORDERS						
OTHER (DESCRIBE)						

CANCER

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
TYPE						
LOCATION						
TYPE						
LOCATION						

RENAL (KIDNEYS & URINARY)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
BLADDER PROBLEMS						
URINARY TRACT INFECTION (FREQUENT)						
KIDNEY INFECTION						
KIDNEY STONES						
KIDNEY DISEASE (DESCRIBE)						
OTHER (DESCRIBE)						

HEPATIC (LIVER)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ELEVATED LIVER ENZYMES						
HEPATITIS						
CIRRHOSIS						
OTHER (DESCRIBE)						

ENDOCRINE (METABOLISM)

DIAGNOSIS						
DIABETES (INSULIN DEPENDENT)						
DIABETES (ORAL MEDICATION)						
DIABETES (DIET CONTROLLED ONLY)						
HYPERTHYROID (OVER ACTIVE)						
HYPOTHYROID (UNDER ACTIVE)						
GOITER						
GOUT						
OTHER (DESCRIBE)						

NEUROLOGICAL (NERVES)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
MIGRAINE HEADACHES						
PARKINSON'S DISEASE						
CVA (STROKE)						
DIABETIC NEUROPATHY						
ALZHEIMER'S DISEASE						
EPILEPSY						
TIA (TRANSIENT ISCHAMIC ATTACK)						
OTHER (DESCRIBE)						

Volunteer Information & Medical History

Are you now or have you been on any Medications?
☐ Yes ☐ No If yes, please list below.

MEDICATIONS

MEDICATION	START DATE	STOP DATE	DOSAGE (strength i.e. mg., units, etc.)	FREQUENCY (times per day, week etc.)	REASON (also see diagnosis and surgery sections that follow)	FORM OF MEDICATION (liquid, pill, injectable, topical inhaler, suppository)

Are you allergic to or intolerant of any Medication?
☐ Yes ☐ No If yes, please list below.

ALLERGIES to MEDICATIONS

MEDICATION	REACTION	DATE FIRST IDENTIFIED	REVIEWER'S COMMENTS

OTHER ALLERGIES

Do you have any "non-medicine" allergies?
YES☐ NO ☐

TYPE	REACTION	DATE FIRST IDENTIFIED	REVIEWER'S COMMENTS
ENVIRONMENTAL / SEASONAL			
ANIMAL			
FOODS (LIST)			

FEMALE REPRODUCTIVE

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Infertility						
Cysts or Lumps in Breasts						
Endometriosis						
Yeast Infections (Frequent)						
Sexually Transmitted Disease(s) (Specify):_____						
Other (describe):_____						

Are you currently pregnant? Yes No

Are you currently breast feeding? Yes No

CURRENT MENSTRUAL STATUS

☐ Post-Menopausal, _____/_____/_____
☐ Hysterectomy, date: _____/_____/_____
☐ Have not yet begun menstruation
☐ Regular periods
☐ Irregular periods
☐ Hormone Replacement *

Date of Last Period: _____/_____/_____

BIRTH CONTROL METHODS (Please check all that apply)

☐ Tubal Ligation
☐ Birth Control Pill *
☐ Barrier (diaphragm, sponge)
☐ Spermicide
☐ Depo-Provera™
☐ I.U.D.
☐ Condoms
☐ Rhythm Method
☐ Abstinence
☐ Norplant™
☐ None
☐ Other
☐ Partner with Vasectomy
☐ **Does not apply** (Post-Menopausal or previous Hysterectomy)

** Please list the names of these medications/hormones under* MEDICATION INFORMATION *on page 2.*

In case of emergency, contact: _____ (Name) _____ (Relationship) ( ) - (Phone)

I certify that the information stated within is true and correct to the best of my knowledge.

_____ Signature of Volunteer

_____ Date

REVIEWED BY:

_____ Signature of Reviewer

_____ Date

MEDICATIONS

MEDICATION	START DATE	STOP DATE	DOSAGE (Strength i.e. mg., units, etc.)	FREQUENCY (times per day, week etc.)	REASON (also see diagnosis & surgery sections that follow)	FORM OF MEDICATION (liquid, pill, injectable, topical inhaler, suppository)

MALE REPRODUCTIVE

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Infertility						
Enlarged Prostate						
Hernia (inguinal)						
Testicular Pain or Masses						
Vasectomy						
Sexually Transmitted Disease(s) (Specify):_____						
Other (describe):_____						

SURGERIES / PROCEDURES/ HOSPITALIZATION

Have you ever had any surgeries/other medical procedures, or hospitalization?
YES ☐ NO ☐

EVENT	DATE(S)	REVIEWER'S COMMENTS