Medical Research Group of Central Florida

Dr. Adly Thebaud and Dr. Josette Romain

PATIENT DEMOGRAPHICS

SUBJECT DEMOGRAPHIC FORM

Full Name (as it appears on ID):			**Complete Mailing** Address (including zip code):	**Phone#:** ( ) -	**Cell phone#:** ( ) -
DOB:	**Age:**	**Gender:** M F	**E-Mail Address:**	**Social Security Number:**	

Race: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

Ethnicity: Hispanic or Latino? ☐Yes ☐ No

Multi-racial (check at least two): ☐ American Indian or Alaska Native ☐ Black ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Referral Source: ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other _____

Your Occupations: What shift do you work? ☐ Days ☐ Nights ☐ Weekends Only Employer: Phone: ( ) -

In Case of Emergency (Name of local friend or relative not living at same address)

Home Phone: ( ) -

Work Phone: ( ) -

Relationship to you:

Drug Use/Abuse: Have you ever used illicit recreational Drugs: ☐Yes ☐ No if **YES**, ____/_____/_____ Date of last use

Have you ever been in a drug or alcohol rehab program? ☐Yes ☐ No if **YES**, when: ____/_____/_____

Social History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed # of Living Children: ____ # of Pregnancies ____ (women)

Caffeine Use History: ☐ Never Drink ☐ Ex-Drinker ☐ Current Drinker # of 8oz Drinks per day ____

Tobacco History: ☐ Never Smoked ☐ Ex-Smoker ☐ Current Smoker (Packs per day ___) Start date: _____ Quit date: _____

Alcohol Use History: ☐ Never Drink ☐ Ex-Drinker ☐ Current Drinker # of Drinks per week ___ # of Drinks per month: ___ Start date: _____ Quit date: _____

ADDITIONAL HISTORY

Male History, N/A ☐

History / Condition	Date	Active
Vasectomy		☐Yes ☐ No
Method of Birth Control:_____		☐Yes ☐ No
Prostate cancer		☐Yes ☐ No
Enlarged prostate		☐Yes ☐ No
Testicular cancer		☐Yes ☐ No
STD		☐Yes ☐ No
Sexual Dysfunctions		☐Yes ☐ No
Low Testosterone		☐Yes ☐ No
Other		☐Yes ☐ No

Female History, N/A ☐

History / Condition	Date	Active
Date of last Period		☐Yes ☐ No
Post-Menopausal		☐Yes ☐ No
Method of Birth Control: _____		☐Yes ☐ No
Hysterectomy		☐Yes ☐ No
Tubal ligation		☐Yes ☐ No
Cyst: _____		☐Yes ☐ No
Cancer: _____		☐Yes ☐ No
		☐Yes ☐ No
Other: _____		☐Yes ☐ No

Family History ☐

History / Condition	Who has this condition?	History / Condition	Who has this condition?
Asthma		Diabetes	
Allergies		Heart Disease	
Emphysema		Chronic bronchitis	
Lung Cancer		Cancer: _____	
Lung Disease		Other: _____	

Patient Printed Name: _____ Signature/Date: _____

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Subject Initials: _____ *Protocol Number: _____*

RELEVANT MEDICAL HISTORY

HISTORY / CONDITION	Date Diagnosed	Active at Start of Study	Treated? If yes, list treatment
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	
	/ /	☐ Yes ☐ No	

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SURGICAL HISTORY

Surgical Procedure	Date of the Procedure	Reason for having this procedure

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CURRENT MEDICATIONS

Medication Name	Dose & Frequency	Route	The reason you take this medication	Start Date	Stop Date