PATIENT'S PERSONAL HISTORY

All records are confidential unless patient authorizes release.

Personal Information

First Name:	Middle Name:	Last Name:
Today's Date:	Date of Birth:	
Sex at birth:	I identify my gender as:	Age:
Race:	Ethnicity: □ Hispanic □ Not Hispanic	
Height: FEET INCHES	Weight: LBS	
Are you a smoker? □ Yes □ No If yes, □ Current or □ Former (please check one) Type: _____ Frequency/Amount: _____	Do you consume alcohol? □ Yes □ No If yes, □ Current or □ Former (please check one) Type: _____ Frequency/Amount: _____	
Address:	City:	State: Zip:
Home Phone #:	Work Phone#:	Cell Phone#:
Is it okay to leave a message?		
List other person(s) we may leave messages with or discuss medical conditions with:		
Email Address:		
Phoeberichmd.com email is encrypted however; your email address may be unencrypted, and your health information will be sent over the internet. May we contact you via email? □ Yes □ No		
Patient Portal: Would you like to be web-enabled and receive messages and receive appointment confirmations via the patient portal? □ Yes □ No □ NA (already enabled)		
Best way to reach you: □ Phone (specify type): _____ □ Email □ Patient Portal		
Name/Place of Employment:	Occupation:	
Who is your primary care provider? _____ □ None Address or phone number of provider: _____ Which pharmacy would you like us to call prescriptions in to? _____ Phone # if available: _____		
Have you seen any provider at this office for non-study related care in the past? □ Yes □ No		

Emergency Contact

In case of emergency, please contact:	
Emergency Contact Phone #:	Relationship to you:

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All Medications Taken Regularly

(Include vitamins, aspirin, Tylenol, nasal sprays, medicated ointments, stomach preparations, ect.)

☐ *Please check box if you are not taking any medications regularly.*

Name of medication	Dose	Frequency Taken	Start Date	Form of Medication *See key	Condition taking medication for
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
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				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	

***KEY:**	*Oral- by mouth (Pill, Tablet, Capsule, Liquid)*	*Nasal*
	Topical- applied to skin (Cream, Ointment, Gel, Liquid, Solution)	*Inhaled*
	Injection- (Sub-cutaneous, intra-muscular)	*Eye Drops*

Allergies

Please list any allergies (medications, food products, tape, etc.):

☐ *Please check box if you do not have any known allergies*

Allergy	Type of Reaction	First noticed Allergy?

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Comprehensive Medical History

Condition	Date Noticed/ Diagnosed	Date Resolved	Are you currently taking a medication for any ongoing condition? Indicate "Yes" or "No" ONLY ONGOING conditions.
Eyes			
Glaucoma ☐ L ☐ R ☐ Both			
Cataracts ☐ L ☐ R ☐ Both			
Corrective Lenses			
Other: _____			
Ears			
Hearing Loss ☐ L ☐ R ☐ Both			
Ringing in ears			
Other			
Nose			
Sinusitis			
Other:_____			
Cardiovascular			
Racing heart (palpitations)			
Angina			
Heart Attack			
Heart murmur			
Heart disease			
High blood pressure			
Swollen feet			
Swollen ankles			
Blood disorders (anemia…)			
Other:_____			
Respiratory			
Asthma			
Hay fever			
Shortness of breath			
Chronic cough			
Bronchitis			
History of tuberculosis			
Sleep Apnea			
Other: _____			
Liver/Kidneys			
Hepatitis ☐ A ☐ B ☐ C			
Kidney stones			
Other: _____			
Gastrointestinal			
Heartburn			
Gallbladder Disease			
Colitis/bowel disease			
Ulcer disease			
Other: _____			

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Condition	Date Noticed/ Diagnosed	Date Resolved	Are you currently taking a medication for any ongoing condition? Indicate "Yes" or "No" ONLY ONGOING conditions.
Neurological			
Frequent Headaches			
Migraine Headaches			
Dizziness			
Epilepsy/seizures			
Stroke			
Other: _____			
Bones and Joints			
Arthritis Type: _____			
Back pain			
Gout			
Bursitis			
Recent Fractures (within last 5 years)			
Other: _____			
Psychological			
Depression			
Insomnia			
Anxiety			
ADHD			
Other: _____			
Endocrinology			
High cholesterol			
Diabetes			
Hyperthyroidism			
Hypothyroidism			
Other:_____			
Urogenital			
Urinary tract infections			
Sexually transmitted disease			If yes, please indicate:
HIV/AIDS			
Other:_____			
Skin			
History of basal cell carcinoma			If yes, location:
History of squamous cell carcinoma			If yes, location:
History of melanoma			If yes, location:
Actinic Keratosis			
Eczema/Dermatitis			
Psoriasis			
Nail fungus			
Athlete's foot			
Ingrown toenails Right/Left			
Warts			
Acne			
Rosacea			
Other:_____			

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Condition	Date Noticed/ Diagnosed	Date Resolved	Are you currently taking a medication for any ongoing condition? Indicate "Yes" or "No" ONLY ONGOING conditions.
Dental			
Other:_____			
Other:_____			
Females Only			
Endometriosis			
Currently Pregnant/Lactating			
Irregular Menstrual Cycle?			
Date of first day of last menstrual period?			
Cancer			
Specify type:			
Specify type:			
Specify type:			
Specify type:			

List Any Past Surgeries Below	Date of Surgery	Reason of Surgery

List any planned surgeries or elective surgeries you will be having done during the timeline of the study

List Any Future Surgeries Below	Date of Surgery	Reason of Surgery

Is there anything else about your health you feel is important for us to know, including anything for which you are taking medication that has not yet been addressed? If yes, list conditions below.

Condition	Date Noticed/ Diagnosed	Date Resolved	Are you currently taking a medication for any ongoing condition? Indicate "Yes" or "No" ONLY ONGOING conditions.

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Pregnancy Prevention

Check the following as it applies to you regarding risk of pregnancy:

Female		
Are you able to get pregnant?	□***Yes*** (Fill out contraception section) □***No*** (If no, complete items below)	
If you are of child bearing potential, is there a chance you could be pregnant?	□***Yes*** □***No*** □***NA***	
Post-menopausal (1 full year without menstruation)	□Yes □No	Year:
Pre-menarche	□Yes □No	Year:
Tubal Ligation	□Yes □No	Year:
Hysterectomy: □Partial □Full □Oophorectomy	□Yes □No	Year:

Female's Able to Get Pregnant		
Females of childbearing potential must choose method of contraception: (pick one)		**Comments:**
Oral contraceptives	□*Yes*	
Norplant	□*Yes*	
Injectable	□*Yes*	
Patch	□*Yes*	
IUD	□*Yes*	
Monogamous relationship with a Partner who has a Vasectomy	□*Yes*	
Vaginal Ring	□*Yes*	
Double Barrier method	□*Yes, choose 2 of the following methods:*	□ Condom □ Spermicidal □ Sponge □ Diaphragm
Sexually abstinent	□*Yes*, I agree to use an acceptable form of birth control if I become sexually active. ***Pt. Initials:*** _____	
Exclusively sexually active with partner of the same sex	□*Yes*	

Male		
Do you agree to take precaution against preventing pregnancy with a female partner?		**□Yes (pick one method below)**
Vasectomy	□*Yes*	Year:
Condom with spermicide	□*Yes*	
Sexually abstinent	□*Yes*, I agree to use an acceptable form of birth control if I become sexually active. ***Pt. Initials:*** _____	
Monogamous with female partner who is not able to get pregnant.	□*Yes* *If Yes, please select reason partner is not of childbearing potential:*	□Post-menopausal, Year: □Tubal Ligation, Year: □Hysterectomy, Year: □Partial □Full □Oophorectomy
Exclusively sexually active with partner of the same sex	□*Yes*	

I certify that the information in this Patient Personal History Form is true:

Participant signature: _____ Date: _____

Patient Personal History Form reviewed with patient by:

Coordinator Signature: _____Date: _____

I certify that I have reviewed this Patient Personal History Form:

Investigator Signature: _____Date: _____