Altus Research

4671 South Congress Avenue
Suite 100-B
Lake Worth, FL 33461

MEDICAL HISTORY

Participant Name/Initials_____ Date_____

CONDITIONS: Check YES or NO column as applicable.

Condition	Yes	No	Description/Comment	Start Date	Ong	Res Date
EYES						
					☐	
					☐	
EARS						
					☐	
					☐	
NOSE or THROAT						
					☐	
					☐	
CARDIOVASCULAR						
					☐	
					☐	
					☐	
					☐	
					☐	
LUNG / RESPIRATORY						
					☐	
					☐	
					☐	
ENDOCRINE						
					☐	
					☐	
GASTROINTESTINAL						
					☐	
					☐	
					☐	
GENITOURINARY						

Participant Name/Initials_____ Date_____

Condition	Yes	No	Description/Comment	Start Date	Ong	Res Date
					☐	
					☐	
					☐	
					☐	
GYNECOLOGICAL						
					☐	
					☐	
					☐	
NEUROLOGICAL						
					☐	
					☐	
					☐	
MUSCULOSKELETAL						
					☐	
					☐	
					☐	
SKIN / INTEGUMENTARY						
					☐	
					☐	
					☐	
EMOTIONAL/ PSYCHOLOGICAL						
					☐	
					☐	
					☐	
					☐	
IMMUNE SYSTEM						
					☐	
					☐	
					☐	
BLOOD DISORDER						
					☐	
					☐	
					☐	
CANCER						

Participant Name/Initials_____ Date_____

Condition	Yes	No	Description/Comment	Start Date	Ong	Res Date
					☐	
					☐	
					☐	

Childbearing Potential:

Is subject a woman of childbearing potential?

☐No – reason_____

☐Yes – type of contraception currently being used, and duration of its use: _____

_____

ALLERGIES (medication, seasonal, food, etc…)	DATE & TYPE OF REACTION:

SURGERIES (please give type of surgery & date):

ALCOHOL USAGE _____NO _____YES _____ EX-USER (If ex-user, please complete prior use)
If yes, how often & what type?_____

TOBACCO USE _____NO _____YES _____ EX-USER (If ex-user, please complete prior use)
If yes, how often & what type?_____

MEDICATIONS – please list on Concomitant Medication page of Source Document

PRIOR INVESTIGATIONAL STUDY
Have you ever taken an investigational medication or participated in a clinical trial? If yes, when did your study participation end? Indicate date_____/_____/_____

Participant Name/Initials_____ Date_____

COMMENTS, UPDATES:

Participant Signature_____ **Date**_____

Reviewed by (clinic staff)_____ **Date**_____

Investigator Signature_____ **Date**_____