M3 Wake Research
MEDICAL HISTORY / PARTICIPANT QUESTIONNAIRE

Name: _____ Preferred Name: _____ Today's Date: ____/____/____
First MI Last

Address: _____ Phone _____ Mobile _____

City: _____ State: _____ ZIP: _____ Email: _____

Birthdate: ____/____/____ Age: _____ SEX: M or F (circle one)

Contact Preference: _____ Height: _____ (inches) Weight : _____ (lbs.)

Race: ❑White/Caucasian ❑Black or African American ❑American Indian or Alaska Native
❑Native Hawaiian Other Pacific Islander ❑Asian/Indian ❑Other, Specify; _____
Ethnicity: ❑Non-Hispanic/Latino ❑Hispanic/Latino ❑Other, Specify: _____

Emergency contact: Name: _____ Phone _____ Relationship: _____

Who referred you to us: _____

Have you been hospitalized in the past 90 days? _____ Yes _____ No _____ Date
For: _____

Have you ever been treated for alcohol use? _____ Yes _____ No _____ Date
Have you ever been treated for drug or other substance use? _____ Yes _____ No _____ Date
Have you donated blood within the past 30 / 60 days? _____ Yes _____ No _____ Date
Have you participated in a research study in past 90 days? _____ Yes _____ No _____ Date

CURRENT PHYSICIANS

Physician's Name	Specialty	Address	Phone Number

Do we have permission to notify your primary care physician of your study participation? ☐Yes ☐ No ☐ I have no PCP

Habits	Current	Never	Past	Date Started	Date Stopped
Caffeine ( ) cups per day					
Alcohol ( ) # of drinks per week					
Cigarettes ( ) pks per week					
Cigars/Chewing Tobacco/Zyn/Pipe/Snuff/Vape					

Allergy History	NO	YES	Date	Reaction
Aspirin / Tylenol / NSAIDS (circle one or all)				
Codeine / Morphine (circle one or both)				
Sulfa Ex: sulfamethoxazole and trimethoprim				
Mycins Ex: Erythromycin				
Penicillin				
Tetracycline				
Latex/ Medical Tape / Adhesive				
Adverse reaction to any influenza vaccine?				
Contrast D ye for MRI or CT?				

Participant Name _____ Date _____/ _____/ _____

Have you ever been diagnosed with these conditions by a physician? Check "yes" or "no" as they relate to your health

Your Health	NO	YES	Start Date	Stop Date	Ongoing (Y or N)
Skin					
Hives type:					
Psoriasis type:					
Atopic Dermatitis/Eczema					
Rosacea /Acne (circle one)					
Eyes					
Difficulty/Impaired Vision					
Cataracts L / R - treatment: Y / N					
Glaucoma L / R - treatment: Y / N					
Dry Eyes					
Macular Degeneration					
Diabetic Retinopathy					
Other:					
Ear, Nose, & Throat					
Seasonal or Environmental Allergies (circle one or both)					
Difficulty/Impaired Hearing					
Chronic Sinusitis / Rhinitis (circle one or both)					
Other:					
Gastrointestinal					
Heartburn / GERD (circle one or both)					
Gastric Ulcers -bleeding? Y / N – location:					
Hiatal / Umbilical Hernia (circle one or both)					
Irritable Bowel Syndrome-type:					
Polyps – location: Benign? Y / N					
Hemorrhoids					
Diverticulosis / litis (circle one or both)					
Crohn's Disease - mild/mod/severe. active / controlled					
Ulcerative Colitis/ Colitis (circle one or both) mild/mod/severe; active / controlled					
Inflammatory Bowel Disease					
Chronic Constipation or Diarrhea (circle one)					
Medication Induced Constipation					
Celiac					
C-Difficile active / resolved					
Other:					
Hematologic					
Clotting Disorder					
Chronic Anemia					
Phlebitis/Thrombophlebitis/DVT (circle one or both)					

Participant Name _____ Date _____/ _____/ _____

Have you ever been diagnosed with these conditions by a physician? Check "yes" or "no" as they relate to your health

Other:					

Your Health	NO	YES	Start Date	Stop Date	Ongoing (Y or N)
Immunologic					
HIV/AIDS – treatment Y / N					
Cancer type: treatment Y / N					
Herpes Simplex: type I or II					
Neurological/Psychological					
Anxiety or Panic Attacks (circle one or both)					
Depression					
Insomnia					
Other Psychiatric Disorder type					
Migraine Headaches with aura / without aura					
Chronic Headaches					
Cluster Headaches					
Seizure Disorder					
Stroke / TIA (circle one or both)					
Meningitis viral / bacteria (circle one)					
Diabetic Neuropathy					
Restless Leg Syndrome					
Other:					
Hepatic/Renal Urogenital/Gynecologic					
Kidney Stones - treatment Y / N					
Chronic Kidney/Urinary Tract Infection Date of most recent infection:					
Overactive Bladder					
Liver Disease type					
Hepatitis A/B/C/D/E (circle one) – treatment Y / N					
Benign Prostate Hypertrophy (BPH)					
Erectile Dysfunction					
Inguinal Hernia					
Sexually Transmitted Disease					
Chronic Kidney Disease: Stage – Dialysis Y / N					
High or Low Potassium (circle one)					
Other:					
Respiratory					
Asthma					
Chronic Bronchitis					
COPD - do you use oxygen? Y or N last exacerbation date:					
Emphysema					

Participant Name _____ Date _____/ _____/ _____

Have you ever been diagnosed with these conditions by a physician? Check "yes" or "no" as they relate to your health

Pneumonia					
Sleep Apnea - do you use a machine? Y or N					
Pulmonary Embolism					
Other:					

Your Health	NO	YES	Start Date	Stop Date	Ongoing (Y or N)
Cardiovascular					
Angina					
Heart Murmur					
Heart Attack					
Irregular Heartbeat / A-FIB					
High Blood Pressure					
High Cholesterol/Triglycerides (circle one or both)					
Peripheral Vascular Disease					
Coronary Artery Disease					
Heart Failure / CHF					
Other:					
Endocrine					
Diabetes Type I or II (circle one)					
Latent Autoimmune Diabetes					
Low or high blood sugar					
High or Low Thyroid (circle one)					
Hashimoto's Disease					
Grave's Disease					
Postmenopausal					
Edema with location:					
Musculoskeletal					
Osteoarthritis with location:					
Rheumatoid Arthritis					
Psoriatic Arthritis					
Ankylosing Spondylitis/Scoliosis (circle one)					
Lupus – Discoid/Systemic (circle one)					
Fibromyalgia					
Chronic pain – location:					
Osteoporosis / Osteopenia (circle one)					
Degenerative Disc Disease – location:					
Gout – location: Date of last gout flare:					
Vitamin D deficiency					
Other:					

Are there any *other* past or current medical conditions not listed? ☐ Yes ☐ No

Diagnosis	Date	Stop Date OR Ongoing
	/ /	/ / **OR** ☐ Ongoing

Participant Name _____ Date _____/ _____/ _____

Have you ever been diagnosed with these conditions by a physician? Check "yes" or "no" as they relate to your health

	/ /	/ /	**OR** ☐ Ongoing
	/ /	/ /	**OR** ☐ Ongoing
	/ /	/ /	**OR** ☐ Ongoing
	/ /	/ /	**OR** ☐ Ongoing
	/ /	/ /	**OR** ☐ Ongoing

Participant Name _____ Date _____/ _____/ _____

Surgical/Hospitalization	NO	YES	Date	Details: What caused the Surgery / Hospitalization?
Appendix				
Gall Bladder				
Tonsillectomy / Adenoidectomy				
Hernia				
Prostate				
Vasectomy				
Hysterectomy Total/Partial				
Cardiac Stent Placement				
Renal/Ureter Stent Placement				
Any planned surgery in next 6 months?				
Plastic Surgery				
Other:				

FAMILY HISTORY

Please indicate if any of your family member(s) have had or have any of the following: ☐ None

Diagnosis	Family Member (s)
☐ Heart Problems	
☐ Cancer	
☐ Stroke	
☐ Diabetes	
☐ Other serious illnesses:	

Participant Name _____ Date _____/ _____/ _____

MEDICATIONS CURRENTLY TAKING OR TAKEN WITHIN THE PAST THIRTY (30) DAYS
PLEASE INCLUDE PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

☐ No current prescription or OTC medications being taken at this time

Medication	Indication (reason why taken)	Dose/ Form	How Often	Route (how taken)	Start Date	Stop Date

VACCINATION HISTORY

Name of Vaccine: Date received	
Last Flu Vaccine:	Covid-19 Vaccine: Booster:
Last Zoster Vaccine (Shingles):	Last Tetanus Booster or TdaP:
Last Pneumococcal (Pneumonia):	Last Vaccine: Booster:

The above medical history and prior/current concomitant medications were reviewed by the Investigator, Study Participant, and Research clinic staff as indicated by the signatures below:

Participant Signature _____ **Date**_____

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

Investigator Signature _____ **Date**_____