M3 WAKE RESEARCH

PARTICIPANT INFORMATION

Today's Date (mm/dd/yyyy)

First Name | MI | Last Name | Preferred Name

Date of Birth (mm/dd/yyyy) | Age | Sex Assigned at Birth: ☐ Male ☐ Female | Gender Identity (if different):

Street Address | City | State | ZIP

Phone | Mobile | Email

Height (in) | Weight (lbs)

Race: ☐ White/Caucasian ☐ Black/African American ☐ Am. Indian/AK Native ☐ Asian/Pacific Islander ☐ Other: ☐ Prefer not to answer

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Other: ☐ Prefer not to answer

Emergency Contact Name / Relationship | Emergency Contact Phone | Referred By

HEALTH & RESEARCH SCREENING

Have you been hospitalized in the past 90 days?	☐ Yes ☐ No
Have you donated blood in the past 60 days?	☐ Yes ☐ No
Have you participated in a research study in the past 90 days?	☐ Yes ☐ No
Is any surgery planned in the next 6 months?	☐ Yes ☐ No
Have you ever been treated for, or are currently being treated for, alcohol use disorder?	☐ Yes ☐ No
Have you ever been treated for, or are currently being treated for, drug or other substance use?	☐ Yes ☐ No

HABITS

	Current	Never	Past	Date Started	Date Stopped
Caffeine (_____ cups/day)	☐	☐	☐		
Alcohol (_____ drinks/week)	☐	☐	☐		
Cigarettes (_____ pks/week)	☐	☐	☐		
Cigars / Chewing Tobacco / Vape / Zyn	☐	☐	☐		
Recreational Marijuana	☐	☐	☐		
Illicit Drug Use	☐	☐	☐		

CURRENT PHYSICIANS

Physician's Name	Specialty	Address	Phone

ALLERGIES

Allergy / Sensitivity	No	Yes	Date / Reaction Details
Aspirin / Tylenol / NSAIDs	☐	☐	
Codeine / Morphine	☐	☐	
Sulfa Drugs	☐	☐	
Macrolides (e.g. Erythromycin)	☐	☐	
Penicillin	☐	☐	
Tetracycline	☐	☐	
Latex / Medical Tape / Adhesive	☐	☐	
Contrast Dye (MRI/CT)	☐	☐	
Influenza Vaccine	☐	☐	
Other:	☐	☐	

KEY MEDICAL HISTORY

Please list all past and current medical conditions in the table below. Common examples by category:

Cardiovascular: *High BP, High Cholesterol, Heart Attack/CAD, Angina, CHF, A-Fib, PVD*
Respiratory: *Asthma, COPD (Emphysema/Bronchitis), Sleep Apnea (CPAP/BiPAP), PE*
Endocrine: *Diabetes (Pre/I/II), Thyroid (Hypo/Hyper), Hashimoto's, Grave's*
GI / Hepatic: *GERD, IBS/IBD, Crohn's, Ulcerative Colitis, Celiac, Liver Disease…*
Neuro / Psych: *Anxiety, Depression, Insomnia, Seizures, Stroke/TIA, Migraines*
Musculoskeletal: *Osteoarthritis, RA/Psoriatic Arthritis, Lupus, Fibromyalgia…*
Renal / Urologic: *CKD, Kidney Stones, Recurrent UTI, Overactive Bladder, BPH…*
Immunologic: *HIV/AIDS, Cancer (type), Skin Cancer, Clotting Disorder, Anemia, DVT*
Skin / Eyes / ENT: *Eczema, Psoriasis, Rosacea, Glaucoma, Cataracts…*
Gynecological: *Birth Control, Endometriosis, STD/STI, Peri/Post-Menopausal*

#	Condition / Diagnosis	Type / Notes	Start Date	Stop Date	Ongoing?
1					☐ Y ☐ N
2					☐ Y ☐ N
3					☐ Y ☐ N
4					☐ Y ☐ N
5					☐ Y ☐ N
6					☐ Y ☐ N
7					☐ Y ☐ N
8					☐ Y ☐ N
9					☐ Y ☐ N
10					☐ Y ☐ N
11					☐ Y ☐ N
12					☐ Y ☐ N
13					☐ Y ☐ N
14					☐ Y ☐ N

FAMILY HISTORY

Please indicate if any immediate family members have had:

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Thyroid Disease Other serious illness:

Details:

CURRENT & RECENT MEDICATIONS (PAST 30 DAYS) — INCLUDE OTC AND SUPPLEMENTS

☐ No prescription or OTC medications currently taken

Medication Name	Indication (Reason)	Dose	Frequency	Route	Start Date	Stop Date

CERTIFICATION

The above medical history and medications were reviewed by the study participant and clinic staff:

Participant Signature Date Reviewed by (Clinic Staff)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name | Date of Birth

Pursuant to my participation in a clinical research trial under M3 Wake Research and its subsidiary sites, I authorize

_____ to disclose my protected health information to:

M3 Wake Research Doctor Name | M3 Wake Research Site

Address | City

Records to Release (check all that apply):

☐ **All Records**

☐ Office Notes / Progress Notes ☐ Operative Report ☐ Laboratory Reports ☐ Emergency Records ☐ Radiology Report / Films

☐ Consultations ☐ History & Physical ☐ Pathology Report ☐ Discharge Summary ☐ Other: _____

By signing below, I understand that:

a. This authorization is voluntary; I may refuse to sign.
b. My research participation at M3 Wake Research is dependent on this authorization.
c. Signing permits release of records (including future records) to the Study Doctor and Institution.
d. I may revoke this authorization in writing at any time; revocation does not apply to already-released information.
e. Disclosed health information may be subject to re-disclosure and may no longer be protected under HIPAA.
f. I will receive a copy of this authorization.
g. This Authorization expires on ____/____/____ (or one year after signing if left blank).

Any facsimile or photocopy of this authorization shall authorize release of the requested records.

Signature of Patient (or Representative) | Date | Printed Name

Description of Authority to Act for Patient (if applicable)

HIPAA VOLUNTEER RECORD OF DISCLOSURES — CONTACT PREFERENCES

The HIPAA privacy rule gives you the right to request restrictions on uses and disclosures of your protected health information (PHI) and to request confidential communications by alternative means. Please indicate how you give permission to be contacted:

Home Telephone: _____ ☐ OK to leave detailed message ☐ Leave callback number only

Work Telephone: _____ ☐ OK to leave detailed message ☐ Callback only

Email: _____ **Text (SMS):** _____

Written Communication: ☐ Home Address ☐ Work / Office Address Fax: _____

HIPAA covered entities must keep records of PHI disclosures. Note: PHI may be disclosed without prior consent in an emergency. Information provided below constitutes an adequate disclosure record.

Volunteer Signature | Date | Date of Birth (mm/dd/yyyy)

Print Name

CONTINUATION PAGE — Use this page if additional space is needed for medical history or medications.

Participant Name | Date of Birth | Today's Date

ADDITIONAL MEDICAL HISTORY (CONTINUED)

#	Condition / Diagnosis	Type / Notes	Start Date	Stop Date	Ongoing?
15					☐ Y ☐ N
16					☐ Y ☐ N
17					☐ Y ☐ N
18					☐ Y ☐ N
19					☐ Y ☐ N
20					☐ Y ☐ N
21					☐ Y ☐ N
22					☐ Y ☐ N
23					☐ Y ☐ N
24					☐ Y ☐ N
25					☐ Y ☐ N
26					☐ Y ☐ N
27					☐ Y ☐ N
28					☐ Y ☐ N
29					☐ Y ☐ N
30					☐ Y ☐ N

ADDITIONAL MEDICATIONS (CONTINUED)

☐ No additional medications

Medication Name	Indication (Reason)	Dose	Frequency	Route	Start Date	Stop Date

CERTIFICATION (Continuation Page)

The information on this continuation page was reviewed by the study participant and clinic staff:

Participant Signature | Date | Reviewed by (Clinic Staff)