Sisters of St. Francis
Health Services

SAINT ANTHONY MEMORIAL

301 West Homer Street,
Michigan City, IN 46360
219.861.8817
fax:219.861.8818

Please fill out this health questionnaire and fax or email to the following:

Fax: 219.861.8817

email:

Medical History

1. Medical History Information

The following questions will help us to develop your medical history profile as it relates to the upcoming study opportunities that we will be considering.

Similar to all the information you have provided, this information is kept strictly confidential. Your information will only be used by the Clinical Research Center to determine your eligibility for clinical studies. This information will not be provided to outside groups without your written permission.

You have the right to remove your name and information from our database at any time.

2. Personal History

* 1. Please provide your first and last name.

First

Last

* 2. Please provide your Date of Birth (DOB).

MM DD YYYY

DOB. / /

3. Please provide your marital status.

- Single
- Partnered
- Married
- Separated
- Divorced
- Widowed

4. Check any area that you HAVE (now) or HAVE HAD (in the past year) any symptoms to a significant degree.

- None
- Skin
- Head/Neck
- Ears
- Nose
- Throat
- Lungs
- Chest/Heart
- Back
- Intestinal
- Bladder
- Bowel
- Circulation
- Weight
- Energy levels
- Sleep
- Pain

Medical History

* 5. Gender

- Male
- Female

3. Mental Health Information

1. Is STRESS a major problem for you?

- Yes
- No

2. Do you feel depressed?

- Yes
- No
- Sometimes

3. Do you panic when stressed?

- Yes
- No
- Sometimes

4. Do you cry frequently?

- Yes
- No

5. Do you have problems with eating or your appetite?

- Yes
- No
- Sometimes

6. Have you ever attempted suicide?

- Yes
- No

7. Have you ever seriously thought about hurting yourself?

- Yes
- No

* 8. Do you have trouble sleeping?

- Yes
- No

4. Women's Health Questions

1. Last date of mensturation.

Date MM / DD / YYYY

2. Period every _____ days?

3. Are you pregnant or breast-feeding?

jn Yes
jn No

4. Have you experienced any recent breast tenderness, lumps or nipple discharge?

jn Yes
jn No

5. Any problems with control of urination?

jn Yes
jn No

6. Any blood in your urine?

jn Yes
jn No

7. Last test date.

	MM		DD		YYYY
PAP		/		/	
Rectal		/		/	

* 8. Have you had any urinary tract, bladder or kidney infections within the last year?

jn Yes
jn No

5. Men's Health Questions

1. Do you usually get up to urinate during the night?

jn Yes
jn No

2. Do you feel pain or burning with urnination?

jn Yes
jn No

3. Date of last exam/test.

	MM		DD		YYYY
Prostate		/		/	
Rectal		/		/	

* 4. Do you have blood in your urine?

jn Yes
jn No

6. Health History

Please answer the following questions to the best of your knowledge.

Medical History

1. Past Surgeries. List most recent ones first.
Include YEAR and REASON.

Surgery 1

Surgery 2

Surgery 3

Surgery 4

Surgery 5

2. List Other Hospitalizations.
List YEAR and REASON.

Other Hospitalization 1.

Other Hospitalization 2.

Other Hospitalization 3.

3. List any allergies you may have. This can include any medications or food.

Allergy 1.

Allergy 2.

Allergy 3.

Allergy 4.

Allergy 5.

* 4. Have you ever had a blood transfusion?

- Yes
- No

7. Health Habits and Personal Safety

This information will help us determine your general living habits.

1. How much do you currently exercise?

- No exercise
- Mild exercise (climb stairs, walk 3 blocks, golf)
- Occasional vigorous exercise(work or recreation, less than 4 X week for 30 minutes.
- Regular vigorous exercise (work or recreation, 4 X week for 30 minutes)

2. Are you dieting?

- Yes
- No
- Yes, I am on a prescribed medical diet

3. What is the number of meals you eat in a day?

- 1
- 2
- 3
- 4
- More than 4

Medical History

4. How would you rank your SALT intake?

- High
- Medium
- Low

* 5. How would you rank your FAT intake?

- High
- Medium
- Low

8. Caffeine Use Question

* 1. Do you routinely consume products with caffiene? (such as coffee, soda, tea)

- Yes
- No

9. Caffeine History

1. How many cups or cans do you consume a day?

Coffee	
Tea	
Cola / Soda	

* 2. If you were asked to participate in a study, would you be able to refrain from using caffeine?

- Yes
- No

10. Alcohol Use Question

* 1. Do you routinely (during a week) consume alcohol products?

- Yes
- No

11. Alcohol Use History

1. List the type of alcohol you drink?

- Beer
- Wine
- Wine Coolers
- Mixed Drinks
- Other

2. How many drinks do you have per WEEK? (enter a number)

3. Alcohol Information

	Yes	No
Are you concerned about the amount you drink?	€	€
Have you considered stopping?	€	€
Have you ever experienced blackouts?	€	€
Are you prone to "binge" drinking?	€	€
Do you drive after drinking?	€	€

* 4. If you were asked to participate in a study, would you be able to refrain from using alcohol?

jn Yes
jn No

12. Tobacco Use Question

* 1. Do you currently smoke or use any tobacco products?

jn Yes
jn No

13. Tobacco History Information

The following information will help us determine your level of tobacco use.

1. How many years have you been using tobacco?

2. How many times a day do you use tobacco?

Cigarettes (packs)	
Chewing Tobacco (times a day)	
Pipe (times a day)	
Cigars (number a day)	

* 3. If you were selected for a study, would you be able to refrain from tobacco use?

jn Yes
jn No

14. Recreational Drugs Use and History

Please provide us with information on your use of recreational drugs (prescription or illegal).

If you are selected to participate in any of these studies, part of the medical evaluation process will include a blood or urine drug screen for typical recreational drugs.

1. Have you ever given yourself street drugs with a needle?

- Yes
- No

* 2. Do you currently use recreational or street drugs?

- Yes
- No

15. Pregnancy

All of the studies will require women to have a negative pregnancy test prior to any participation.

* 1. Are you at risk of becoming pregnant?

- Yes
- No

16. Personal Safety

1. Do you live alone?

- Yes
- No

2. Do you have vision or hearing loss?

- Neither
- Vision only (such as wearing glasses)
- Hearing only (such as hearing aids)
- Both Vision and Hearing

* 3. Do you have frequent falls?

- Yes
- No

17. Thank you!

You have just completed a brief Medical History.

Your information will be put on our database and used to match your information with potential studies.

If you need to change or amend any of your information, contact us directly at the Saint Anthony Memorial Clinical Research Center:

Phone 219-861-8817
Fax 219-861-8818