Clinical Research Institute

Medical History Form

Please fill out this form as completely as possible and bring it to your first research study appointment.

Name: _____ Date: _____

DOB: _____ Gender: Male / Female

First onset of COPD symptoms _____ **First diagnosed with COPD** _____
(MONTH / YEAR) **(MONTH /DAY /YEAR)**

Number of COPD episodes (requiring oral steroids/antibiotics) **in the past 12 months?** _____

Date of most recent COPD episode (comment if estimated date) _____

Type of treatments received for your most recent COPD episode?

Oral corticosteroids (Prednisone) YES NO _____
(NAME OF DRUG)

Antibiotics YES NO _____
(NAME OF DRUG)

Type of daily COPD symptoms: Breathlessness □ with activity □ without activity

Cough Increased Sputum Wheeze Night-time awakenings

Bronchitis Phlegm Dyspnea Other _____

Current smoker YES / NO

Ex-smoker YES / NO Year started_____**Year Quit**_____

If quit smoking more than once please provide those dates also:

Year started_____**Year quit**_____ **Year started**_____**Year quit**_____

Occasional smoker YES / NO Habitual smoker YES / NO

Average number of packs smoked per day _____

Do you have any drug allergies? □ No □ Yes- please complete the following:
Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____
Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other_____

Have you ever had surgery? _ No _ Yes –Describe date and type of surgery.
_____
_____
_____
_____

Have you ever been hospitalized except for a surgery? _ No _ Yes-Describe date and reason_____
_____
_____
_____
_____

(OVER)

Please tell us if you currently have or have had a past history of any of the following conditions.
If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

Ears/Eyes/Throat Problems with your eyes, ears or throat? ☐ No ☐Yes _____
Mouth/throat problems (infections, hoarseness)
Cataracts? ☐ No ☐Yes _____
Head/Nose ☐ No ☐Yes _____
Speech or hearing problems? ☐ No ☐Yes _____
Headaches (cluster, tension, migraines) or seizures? ☐ No ☐Yes _____
Sinus problems (allergies, loss of smell,
nasal polyps, sinus infections)? ☐ No ☐Yes _____
Problems with vision? ☐ No ☐Yes _____
Emotional: Do you feel nervous, angry, suicidal, depressed,
lonely, sad or out of control? ☐ No ☐Yes _____
Do you have trouble sleeping? ☐ No ☐Yes _____
Endocrine: Diagnosed with diabetes? When/type _____ ☐ No ☐Yes _____
Do you have thyroid disease? ☐ No ☐Yes _____
Circulatory: Heart problems (high blood pressure, palpitations,
chest pain, irregular heart beat)? ☐No ☐Yes _____
Respiratory: Lung problems (bronchitis, pneumonia, TB,
asthma)? ☐ No ☐Yes _____
Gastrointestinal: Recent problems with eating, drinking? ☐ No ☐Yes _____
Problems with nausea, vomiting, abdominal pain,
or bloody stools? ☐No ☐ Yes _____
Recent weight changes or change in appetite within
the last 3 months? ☐ No ☐Yes _____
Ulcers, hernias, indigestion, cirrhosis, or hepatitis? ☐ No ☐Yes _____
Genital/Urinary: Burning, pain or frequency when urinating? ☐ No ☐Yes _____
Have you been treated for a sexually transmitted
disease? If yes, what _____ ☐ No ☐Yes _____
Have you had kidney stones, prostate infection
(male), or urinary tract (bladder) infection? ☐ No ☐Yes _____
Immune: Cancer, blood diseases, deficiencies, anemia? ☐ No ☐Yes _____
Mobility: Muscular/joint (i.e. arthritis) bone/orthopedic problems
or difficulty with coordination? ☐ No ☐Yes _____
Skin: Problems with your skin (rash, hives, changes in
skin/hair, cold sores, eczema)? ☐ No ☐Yes _____

MEDICATIONS –list all medications (including prescription and over-the-counter) used in the past 6 months.

MEDICATION	DOSE	START DATE
Example: Ibuprofen	Two 200 mg tablets	April 15, 2011

☐ I consent to having the health information which I have provided on this form being collected and stored solely to assess my qualification for possible participation in a clinical research study at Clinical Research Institute, Inc.

Signature: _____ Date: _____