Preferred Research Partners

Medical Health Questionnaire

Patient Name:_____ Date of Birth:_____

Sex: ☐ Male ☐ Female **Phone:**_____ **Email:**_____

Do we have your permission to email you? ☐ Yes ☐ No

Do we have your permission to text you? ☐ Yes ☐ No

Study Screening

Are you currently enrolled in another research study? ☐ Yes ☐ No

How did you hear about Preferred Research Partners? ☐ Facebook ☐ Instagram ☐ Website ☐ Other:_____

Medical History Check box if no medical history ☐NONE

Condition	Yes	Description	Start Date	Ongoing	Medication
Anemia / Blood Disease	☐			☐	
Arthritis / Rheumatism	☐			☐	
Asthma / Breathing Problems	☐			☐	
Breast Problems	☐			☐	
Cancer or Tumors	☐			☐	
Cardiac History	☐			☐	
Diabetes	☐			☐	
Eye Problems	☐			☐	
Ear Problems	☐			☐	
Epilepsy, Seizures	☐			☐	
High Blood Pressure	☐			☐	
High Cholesterol	☐			☐	
Kidney / Bladder Issues	☐			☐	
Liver / Gallbladder Issues	☐			☐	
Musculoskeletal Issues	☐			☐	
Nose Problems	☐			☐	
Psychiatric History	☐			☐	
Prostate History	☐			☐	
Skin Issues	☐			☐	
Sleep Disorders	☐			☐	
Stomach / Bowel Disorders / Ulcers	☐			☐	
Uterine / Ovarian / Cervical	☐			☐	
Other	☐			☐	

Do you have any implanted medical devices? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, please describe:_____

CONSENT CONFIRMATION

I confirm the information provided is accurate to the best of my knowledge without medical record(s) and understand this information is used for research screening and safety.

Participant Signature:_____ Date:_____