REGISTRATION FORMS

PERSONAL INFORMATION

NAME:_____ **MALE ☐ FEMALE ☐**

DATE OF BIRTH:_____ **AGE:**____ **SS#:**_____
ADDRESS:_____ **APT**_____
CITY:_____ **STATE:**_____ **ZIP:**_____

CONTACT INFORMATION

HOME/CELL:_____ **WORK:**_____
OTHER:_____ **EMAIL:**_____

ETHNIC ORIGIN

☐ AFRICAN AMERICAN **☐ HISPANIC**
☐ ASIAN **☐ NATIVE AMERICAN**
☐ CAUCASIAN **☐ OTHER** _____

BEST DAY(S) AND TIME(S) TO CONTACT YOU:_____
BEST DAY(S) FOR APPOINTMENTS:_____

CAN WE LEAVE A VOICEMAIL? YES ☐ NO ☐
CAN WE SEND YOU A TEXT MESSAGE? YES ☐ NO ☐

EMERGENCY CONTACT

CONTACT PERSON:_____ **PHONE:**_____
RELATIONSHIP: _____
ADDRESS: _____ **APT**_____
CITY:_____ **STATE:**_____ **ZIP:**_____

PARTICIPANT AGREEMENT

I understand Preferred Research Partners will not be providing Investigational treatment for my medical condition unless I have qualified for and have entered a research study. I also understand that if I do enter a study, I will only receive Investigational treatment for the medical condition being studied.

SIGNATURE:_____ **DATE:**_____

ADVERTISING/REFERRAL SOURCE:_____

Forms updated 29DEC2025

MEDICAL HISTORY

Participant Name:_____ **DOB:**_____ **AGE:**_____

Condition	Yes	No	Description/Comment	Start Date	Ongoing	Resolution Date
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	☐	☐			☐	
Musculoskeletal Issues	☐	☐			☐	
Nose Problems	☐	☐			☐	
Psychiatric History	☐	☐			☐	
Prostate Issues	☐	☐			☐	
Skin Issues	☐	☐			☐	
Sleep Disorders	☐	☐			☐	
Stomach/Bowel Issues/Ulcers	☐	☐			☐	
Uterine/Ovarian/Cervical	☐	☐			☐	
Other	☐	☐			☐	

Medical History Continued

Participant Name: _____

Surgeries/Hospitalizations (Check "S" if Surgery or "H" if hospitalization. Check NONE if no history)

List all Including Childbirth **NONE ☐**

S	H	Surgery / Hospitalizations	Date	Reason
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

Allergies: List all including environmental, food, dyes, and medications: NONE ☐

Allergy	Reaction	Date

Social History

Tobacco:
☐ Never Used **Start date:**_____ **# of cigarettes/day:**_____
☐ Ex-user **Stop date:**_____ **# of cigars/day:**_____
☐ Currently use **# of pipefuls/day:**_____
# of pinches/day:_____

Alcohol:
☐ Never Used **Beer: # cans/day:**_____
☐ Ex-user **Start date:**_____ **Wine: # glasses/day:**_____
☐ Currently use **Stop date:**_____ **Liquor: # drinks/day:**_____

Caffeine:
☐ Never used **# ounces/day:**_____
☐ Ex-user **Start date:**_____
☐ Currently use **Stop date:**_____

Medical History Continued

Participant Name:_____

FOR WOMEN ONLY **Date of last menstrual cycle:**_____

Section A: ☐ Able to have children. Check primary birth control method used:

☐	Oral Contraceptive Pill	☐	Condoms Only	☐	Diaphragm & foam/gel
☐	Injection	☐	Absinence	☐	NONE
☐	Implant	☐	Withdrawal	☐	Other, type:
☐	Vasectomized partner	☐	Vaginal Condom		
☐	Condoms & foam/gel	☐	IUD		

Section B: ☐ Non-childbearing by means of: (check one and specify date)

☐	Hysterectomy	Date:
☐	Tubal Ligation	Date:
☐	Bilateral Oophorectomy	Date:
☐	Natural Post-Menopause	Date of last menstrual cycle:

Medications: Over the Counter, Herbal, or Prescription **NONE ☐**

Medication	Dose	# times/day	Reason	Start date	Ongoing	Stop date
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Participant Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____