

PROGRESSIVE MEDICAL RESEARCH SUBJECT MEDICAL HISTORY/Concomitant Meds

DATE: _____

Name: _____ SEX: M or F _____ Birthdate: _____ Age: _____
First MI Last

Address: _____ Phone 1 _____ Phone 2 _____

City: _____ State: _____ ZIP: _____ Email _____

Race: _____ Height: _____ (in) _____ cm Weight: _____ (lbs.) _____ (Kg) BMI _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino SS#: _____

Primary Physician: _____ address & phone number: _____

Referred by: _____ (Doctor Referral, Website, subject/patient, or other)

Please review these health conditions/disease, check "yes" or "no" as they relate to your health and provide the dates

Your Health	YES	NO	Start Date (mm/dd/yr)	Stop Date (mm/dd/yr)	Ongoing (Y or N)
<u>RESPIRATORY</u>					
Asthma					
COPD / Emphysema					
Chronic Bronchitis					
Sleep Apnea					
Other pulmonary:					
<u>CARDIOVASCULAR</u>					
Coronary Artery Disease/heart disease					
Heart Attack (Myocardial Infarction)					
Percutaneous Coronary I (Stent)					
Coronary Artery Bypass Surgery					
Congestive Heart Failure					
Atrial fibrillation					
Stroke/Cerebral vascular disease					
Carotid Artery Disease					
Peripheral Artery Disease					
Hypertension (High Blood Pressure)					
Hypercholesterolemia (High Cholesterol)					
Hyperlipidemia (High Triglycerides)					
Other cardiovascular					
<u>METABOLIC/ENDOCRINE</u>					
Thyroid Disease Hypo					
Thyroid Disease Hyper					
Diabetes: Type 1 IDDM /					
Diabetes Type 2 NIDDM					
Obesity					
<u>DERMATOLOGY</u>					
Psoriasis					
Eczema					

Attachment SM 403-A Medical History /Concomitant Medications Cont'd Page 2 of 4	YES	NO	Start Date (mm/dd/yr)	Stop Date (mm/dd/yr)	Ongoing (Y or N)
<u>MUSCULOSKELETAL</u>					
Osteoarthritis location:					
Chronic Low Back Pain:					
Osteoporosis					
Osteopenia					
Gout					
Rheumatoid Arthritis					
Fibromyalgia					
<u>GASTROINTESTINAL</u>					
Ulcers:					
Gastroesophageal Reflux Disease (GERD)					
Heartburn					
Irritable Bowel Disease					
Crohn's Disease					
Fatty Liver Disease					
Hepatitis					
<u>GENITOURINARY</u>					
Post-Menopausal <input type="checkbox"/> N/A					
Chronic Urinary Infections					
Hematuria (blood in urine)					
Chronic Kidney Disease					
Kidney Stones					
Erectile Dysfunction <input type="checkbox"/> N/A					
<u>NEUROLOGICAL</u>					
Alzheimer's Disease					
Dementia/Cognitive Impairment					
Peripheral Neuropathy					
Parkinson's Disease					
Migraine Headaches					
Post herpetic neuralgia (Shingles)					
Depression					
Anxiety					
Bipolar Disease					
Insomnia					
Post Traumatic Stress Disease					
<u>HEENT</u>					
Glaucoma					
Seasonal allergies					
<u>CANCER</u>					
Cancer Location:					
<u>FAMILY HISTORY</u>					
Alzheimer's Disease					
Demential or Cognitive Impairment					

MEDICAL HISTORY/Concomitant Medications Continued*Enter dates if apply*

Surgical History	Date (mm/dd/yr)	Related Medical History	Date (mm/dd/yr)
Appendectomy			
Prostatectomy			
Cholecystectomy			
Herniorrhaphy			
Partial Hysterectomy			
Total Hysterectomy			
Tubal Ligation (Tubes Tied)			
Vasectomy			
Traumatic Injury			
Pacemaker			
Spinal Stimulator			

ALLERGY HISTORY

Allergy	Date Year	Reaction	Allergy History	Date Year	Reaction
Aspirin			Sulfa		
Codeine			Mycins		
Morphine			Penicillin		
Oxycodone			Tetracycline		
Other:					

CAFFEINE *Check all that apply* Intake: ☐ None ☐ caffeinated coffee, tea or sodas*Check amount* ☐ 1 cup ☐ 2 cups ☐ 3 cups ☐ 4 cups ☐ > 4 # _____☐ daily ☐ week ☐ month ☐ occasionally**ALCOHOL:** ☐ None If yes *Check all that apply* ☐ Wine ☐ 5oz. ☐ 8 oz glasses ☐ daily ☐ week ☐ month ☐ occasionally☐ Hard alcohol *How many ounces* ☐ 1 oz. ☐ 2 oz ☐ 3 oz ☐ other _____ ☐ daily ☐ week ☐ month ☐ occasionally☐ Beer ☐ 8 oz. ☐ 12 oz ☐ 16 oz. ☐ 24 oz ☐ other _____ ☐ daily ☐ week ☐ month ☐ occasionally**SMOKING/NICOTINE:** *Check all that apply* If you smoke *cigarettes* Year started _____ Number of packs per day _____Other tobacco/nicotine: ☐ Cigars ☐ Pipe ☐ Chewing tobacco ☐ Snuff ☐ e cigarettes ☐ patches Year started _____ # Packs/day _____If not currently smoking, have you ever smoked? ☐ No If yes Year started _____ Year stopped? _____ # of packs per day _____Are there any *other* past or current medical conditions/surgeries not listed? _____ If yes, please list: *(include dates)*

MEDICAL HISTORY/Concomitant Medications/Vaccine History****Enter Dates Below- if applicable**

COVID	INFLUENZA	PNEUMOVAX	AZ Evusheld	SHINGRIX	RSV	Tetanus	OTHER	

Your CURRENT MEDICATIONS:

Medication (includes Rx/over the counter All supplements/herbals/vitamins)	Indication (reason why taken)	Dose	Route (Ex: Oral, Injection)	How Often	Start Date (mm/dd/yr)	Stop Date (mm/dd/yr)

*Concomitant medications started or stopped after screen date are to be captured on the concomitant med log – Use additional page if needed***Please list a contact person that may be reached in case of an emergency:**

Name: _____

Relationship: _____

Address: _____

Phone: _____

Subject Signature: _____ **Date** _____

Staff Signature: _____ Reviewed PMR Medical History/Con Meds with Subject Date: _____