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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_____

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)
RESPIRATORY					
Asthma					
COPD / Emphysema					
Chronic Bronchitis					
Sleep Apnea					
Other pulmonary:					
CARDIOVASCULAR					
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					
METABOLIC/ENDOCRINE					
Thyroid Disease Hypo					
Thyroid Disease Hyper					
Diabetes: Type 1 IDDM /					
Diabetes Type 2 NIDDM					
Obesity					
DERMATOLOGY					
Psoriasis					
Eczema					
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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)
MUSCULOSKELETAL					
Osteoarthritis location:					
Chronic Low Back Pain:					
Osteoporosis					
Osteopenia					
Gout					
Rheumatoid Arthritis					
Fibromyalgia					
GASTROINTESTINAL					
Ulcers:					
Gastroesophageal Reflux Disease (GERD)					
Heartburn					
Irritable Bowel Disease					
Crohn's Disease					
Fatty Liver Disease					
Hepatitis					
GENITOURINARY					
Post-Menopausal ☐ N/A					
Chronic Urinary Infections					
Hematuria (blood in urine)					
Chronic Kidney Disease					
Kidney Stones					
Erectile Dysfunction ☐ N/A					
NEUROLOGICAL					
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					
HEENT					
Glaucoma					
Seasonal allergies					
CANCER					
Cancer Location:					
FAMILY HISTORY					
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)*

Your CURRENT MEDICATIONS:

Medication (includes Rx/over the counter/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: _____