

LBCCR

LONG BEACH CENTER FOR CLINICAL RESEARCH

2865 Atlantic Ave. Suite 227 Long Beach, CA 90806 (562) 595-9366 Fax (562) 595-7829

INITIAL MEDICAL HISTORY QUESTIONNAIRE

NAME		ETHNICITY (RACE)		DATE
DATE OF BIRTH	AGE	SEX		

PERSONAL INFORMATION

ALCOHOL CONSUMPTION: NEVER SOCIAL DAILY OZ/DAY OZ/WK						
SMOKING:	NEVER	QUIT	AGE WHEN QUIT:	CURRENT SMOKER:	PACKS/DAY	YEARS SMOKED
EXERCISE: TYPE OF EXERCISE						FREQUENCY PER WEEK:
ALLERGIES: (PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO)						OTHER ALLERGIES (food, plants, animals):

FAMILY HISTORY

MOTHER	ALIVE DECEASED	AGE:	IF DECEASED, AGE AND CAUSE OF DEATH:
FATHER	ALIVE DECEASED	AGE:	IF DECEASED, AGE AND CAUSE OF DEATH:

PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION AND DOSE	DATE STARTED:	REASON
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY

PLEASE INDICATE ALL OF THE CONDITIONS FOR WHICH YOU HAVE RECEIVED OR ARE CURRENTLY RECEIVING TREATMENT. PLEASE ALSO TRY TO REMEMBER THE DATE OF EACH DIAGNOSIS AND NOTE WHETHER THE PROBLEM IS ACTIVE OR INACTIVE.

HEART PROBLEMS:

				Date of Diagnosis	Comments/Results
HIGH BLOOD PRESSURE	NO	YES	ACTIVE		
HEART ATTACK	NO	YES	ACTIVE		
CHEST PAINS	NO	YES	ACTIVE		
PALPITATIONS(IRREGULAR HEART BEAT)	NO	YES	ACTIVE		
HEART MURMUR	NO	YES	ACTIVE		
ANGIOGRAM OR ANGIOPLASTY	NO	YES			
HEART BYPASS OPERATION	NO	YES	WHEN		
BLOOD CLOTS	NO	YES	ACTIVE		
CONGESTIVE HEART FAILURE	NO	YES	ACTIVE		

LUNG PROBLEMS:

				Date of Diagnosis	Comments/Results
EMPHYSEMA	NO	YES	ACTIVE		
ASTHMA	NO	YES	ACTIVE		
CHRONIC BRONCHITIS	NO	YES	ACTIVE		
COUGH IN RESPONSE TO MEDICATION	NO	YES	ACTIVE		
CHRONIC COUGH	NO	YES	ACTIVE		
OBSTRUCTIVE SLEEP APNEA	NO	YES	ACTIVE		

STOMACH PROBLEMS:

				Date of Diagnosis	Comments/Results
ULCER	NO	YES	ACTIVE		
HEARTBURN	NO	YES	ACTIVE		
CONSTIPATION	NO	YES	ACTIVE		
DIARRHEA	No	Yes	Active		
BLOOD IN STOOLS	NO	YES	ACTIVE		
HEPATITIS A, B, OR C	NO	YES	ACTIVE		
IRRITABLE BOWEL DISEASE	NO	YES	ACTIVE		
GASTROESOPHAGEAL REFLUX DISEASE (GERD)	NO	YES	ACTIVE		
SIGMOIDOSCOPY/COLONOSCOPY	NO	YES	ACTIVE		
DIVERTICULITIS	NO	YES	ACTIVE		

ENDOCRINE AND METABOLIC PROBLEMS:

				DATE OF DIAGNOSIS	COMMENTS/RESULTS
<input type="checkbox"/> Type I <input type="checkbox"/> Type II DIABETES Last HbA1C Last Glucose	NO	Yes	Active		
EVER TREATED WITH INSULIN	No	Yes			
THYROID DISEASE	NO	Yes	ACTIVE		
GOUT	NO	Yes	ACTIVE		
HIGH LIPIDS (CHOLESTEROL, TRIGLYCERIDES, LDL).	No	Yes	ACTIVE		

Coordinator Initials _____

NAME: _____

NERVE Problems:

				Date of Diagnosis	Comments/Results
SEIZURES	NO	YES	ACTIVE		
STROKE	NO	YES	ACTIVE		
HEADACHES/STRESS TENSION/MIGRANE	NO	YES	ACTIVE		
NEUROPATHY	NO	YES	ACTIVE		
CARPAL TUNNEL SYNDROME	NO	YES	ACTIVE		

MENTAL HEALTH PROBLEMS:

				Date of Diagnosis	Comments/Results
ANXIETY NEEDING TREATMENT	NO	YES	ACTIVE		
DEPRESSION NEEDING TREATMENT	NO	YES	ACTIVE		
INSOMNIA	NO	YES	ACTIVE		

KIDNEY/BLADDER PROBLEMS:

				Date of Diagnosis	Comments/Results
Stress/urge Incontinence	No	Yes	ACTIVE		
Chronic Urinary Tract Infections	NO	YES	ACTIVE		
Night Time Urination	NO	YES	ACTIVE		
BLOOD OR PROTEIN IN URINE	NO	YES	ACTIVE		
KIDNEY DISEASE	NO	YES	ACTIVE		
<u>WOMEN: MENOPAUSE</u>	NO	YES	ACTIVE		LAST MENSTRUAL PERIOD
NIGHT SWEATS	No	Yes	Active		
DIFFICULTY SLEEPING	No	Yes	Active		
<u>WOMEN: HYSTERECTOMY</u>	NO	YES	Total _____ Partial _____		WHY:
<u>WOMEN: BIRTH CONTROL METHOD</u>	NO	YES	TYPE: B.C. Pills Tubal Ligat. Diaphragm Condom Spermicide IUD		LAST PAP SMEAR
<u>WOMEN: MAMMOGRAM</u>	NO	YES			
<u>WOMEN: BREAST LUMPS</u>	NO	YES			LAST MAMMOGRAM
<u>MEN: ENLARGED PROSTATE</u> <input type="checkbox"/> <input type="checkbox"/>	NO	YES			PSA Results _____ Biopsy No Yes
<u>MEN: IMPOTENCE</u>	NO	YES			

BLOOD PROBLEMS:

				Date of Diagnosis	Comments/Results
ANEMIA	NO	YES	ACTIVE		
AIDS OR HIV INFECTION	NO	YES	ACTIVE		

SKIN PROBLEMS:

				Date of Diagnosis	Comments/Results
RASHES	NO	YES	ACTIVE		
ECZEMA	NO	YES	ACTIVE		
PSORIASIS	NO	YES	ACTIVE		

Coordinator Initials _____

EYE, EAR, NOSE OR THROAT PROBLEMS:

NAME: _____

	Date of Diagnosis			Comments/Results
GLAUCOMA	NO	YES	ACTIVE	
CATARACTS	NO	YES	ACTIVE	
SINUSITIS	NO	YES	ACTIVE	
ALLERGIC RHINITIS	NO	YES	ACTIVE	
HEARING LOSS	NO	YES	ACTIVE	
OTHER	NO	YES	ACTIVE	

JOINT AND MUSCLE PROBLEMS:

	Date of Diagnosis			Comments/Results
RHEUMATOID ARTHRITIS	NO	YES	ACTIVE	
OSTEOARTHRITIS/DEGENERATIVE JOINT DISEASE	NO	YES	ACTIVE	
ANKLE SWELLING	NO	YES	ACTIVE	Cause:
<u>CANCER:</u>				
BREAST	NO	YES	ACTIVE	THERAPY:
PROSTATE	NO	YES	ACTIVE	
CERVIX/UTRERUS/OVARIAN	NO	YES	ACTIVE	
SKIN	NO	YES	ACTIVE	
LUNG	NO	YES	ACTIVE	
COLON	No	YES	ACTIVE	

<u>Abnormal lab results:</u>	NO	YES	D/W staff

PLEASE LIST ALL YOUR PREVIOUS OPERATIONS AND HOSPITALIZATIONS:

OPERATION OR HOSPITAL STAY	DATE:	PHYSICIAN NOTES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Have you participated in any research program with in the last 6 months? Yes ___ No ___

If yes, for what medical condition? _____

When? _____

Where? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

Coordinator Initials _____

Name _____

BASELINE EVALUATION

NAME: _____

Weight: _____ Height: _____ BMI: _____

Dominant Arm L or R
Arm Circumference L _____ R _____

BP: _____ HR: _____

URINE

BP: _____

Nitrites _____

BP: _____

Leukocytes _____

Blood _____

Protein _____

FBS _____

HbA1C _____

Observer Signature: _____

Initial problem list: (Please include all significant diagnosis)

PLAN:

- Obtain Records
- Return _____
- Recontact
- Re-evaluate

Physician Signature Date

BASELINE PHYSICAL EXAMINATION

DATE: _____

GENERAL APPEARANCE:

FUNDI: normal I II III IV DIABETES

NAME: _____

HEENT		normal	abnormal
THYROID		normal	abnormal
CAROTIDS		normal	abnormal
LYMPH NODES		normal	abnormal
BREASTS		normal	abnormal
LUNGS		normal	abnormal
HEART: rhythm		normal	abnormal
murmur		normal	abnormal
	S3	normal	abnormal
	S4	normal	abnormal
ABDOMEN	bruit	normal	abnormal
	organomegaly	normal	abnormal
	masses	normal	abnormal
RECTAL	not done	normal	abnormal
HEMOCCULT	not done	normal	abnormal
EXTREMITIES	edema	normal	abnormal
	pulses	normal	abnormal
NEUROLOGIC		normal	abnormal
SKIN		normal	abnormal
JOINTS		normal	abnormal
OTHER		normal	abnormal

 Physician Signature

Date

NAME: _____