

# Quintiles Phase I Male Medical History

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## DEMOGRAPHIC DATA

**Name:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: Day \_\_\_\_\_ Evening \_\_\_\_\_

Cell phone: \_\_\_\_\_ May we text you?  Yes  No

Best Number to reach you:  Day  Evening  Cell

May we leave a message if not answered?  Yes  No

Occupation: \_\_\_\_\_ E-mail \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Hospital: \_\_\_\_\_

Would you like Quintiles to notify your physician of your potential participation in this trial?  Yes  No

To ensure that your physician gets notified of your participation you must complete name, address, city, and state where they are located.



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**2. List ALL past hospitalizations and surgeries:**

PLEASE USE MM/DD/YY FORMAT FOR ANY DATES GIVEN

List REASON/ILLNESS or <input type="checkbox"/> NONE Example: (Laparoscopic Inguinal Hernia Repair)	Where (hospital or city)	Date (01/15/09)	COMMENTS (planned - no complications)

**3. List ALL Drug Allergies:**

PLEASE USE MM/DD/YY FORMAT FOR ANY DATES GIVEN

List DRUG ALLERGIES or <input type="checkbox"/> NONE Example: (Aspirin)	Onset Date (01/15/09)	Date of Last Occurrence (03/01/09)	Ongoing <input checked="" type="checkbox"/>	What happened to you (hives)

# Quintiles Phase I Male Medical History

**Medical History:** Please check yes to all that apply, either **previous or current** or check None. Explain each yes in the space provided at the end of the selections (on page 3).

SKIN		DENTAL/THROAT		GASTROINTESTINAL	
Yes	or <input type="checkbox"/> None	Yes	or <input type="checkbox"/> None	Yes	or <input type="checkbox"/> None
	Skin problems, rash, itching		Poor teeth/gums		Vomited blood
	Cuts that won't heal		Wear dentures		Passed blood in stool
	Change in skin color or moles		Unexplained hoarseness		Black stools
	Skin lumps or tumors		Bleeding gums		Recurrent nausea
	Skin biopsies		Swollen glands or lumps in neck		Recurrent vomiting
	Other _____		Other _____		Hemorrhoids
EYES		CHEST/LUNGS			Change in bowels
Yes	or <input type="checkbox"/> None	Yes	or <input type="checkbox"/> None		Change in appetite
	glasses/contacts (circle which) Distance (myopia) Reading (hyperopia/presbyopia) Astigmatism		Asthma (circle which) Childhood With exercise Adult onset		Weight loss
	Light sensitivity		Shortness of breath		Gallbladder trouble/removal
	Excess tearing		Chronic cough		Abnormal liver function tests
	Cataracts		Coughed up blood		Heartburn or reflux
	Glaucoma		Positive TB skin test		Hepatitis
	Chronic eye problems		Pneumonia		Special diet
	Other _____		Chronic bronchitis or emphysema		Difficulty swallowing
EARS			Abnormal chest x-ray		Difficulty swallowing pills
Yes	or <input type="checkbox"/> None		Other lung disease		Other _____
	Hearing loss (Right, left, or both)		Other _____	URINARY SYSTEM	
	Frequent earaches	HEART		Yes	or <input type="checkbox"/> None
	Ringing in ears	Yes	or <input type="checkbox"/> None		Bladder infection
	Frequent ear discharge		Chest pain		Kidney failure
	Other _____		Heart attack		Kidney infection
NOSE			Heart murmur		Kidney stones
Yes	or <input type="checkbox"/> None		High blood pressure		Involuntary loss of urine
	Sinus problems		Irregular heart beats		Urinate at night
	Allergic congestion		Ankle swelling		Pain on urination
	Non-allergic congestion		Leg cramps with exercise		Blood in urine
	Recurrent sneezing		Varicose veins		Difficulty urinating
	Nasal discharge		Elevated cholesterol (list past or present treatment in comments)		Other _____
	Nosebleeds		Elevated triglycerides (list past or present treatment in comments)	ENDOCRINE	
	Nasal polyps		Prior electrocardiogram	Yes	or <input type="checkbox"/> None
	Other _____		Prior Holter monitor		Recurrent fatigue
			Prior stress test		Thyroid trouble
			Prior echocardiogram		Heat intolerance
			Other _____		Cold intolerance
					Diabetes
					Elevated blood sugar
					Other _____

# Quintiles Phase I Male Medical History

**Medical History continued.** Please check yes to all that apply, either **previous or current** or check None. Explain each yes in the space provided at the end of the selections (below).

MUSCULOSKELETAL		NEUROLOGIC		PSYCHIATRIC	
Yes	or <input type="checkbox"/> None	Yes	or <input type="checkbox"/> None	Yes	or <input type="checkbox"/> None
	Recurrent muscle pain		Headaches (More than once a week)		Inpatient treatment for emotional problems
	Muscle wasting		Migraines		Outpatient treatment for emotional problems
	Muscle weakness		Head injury		Treatment for alcohol abuse
	Joint stiffness/pain		Fainting spells		Treatment for substance abuse
	Arthritis		Memory problems		Treated for depression
	Gout		Dizzy spells		Suicidal thoughts
	Recurrent backaches		Seizures		Suicide attempt(s)
	Broken bones (list below)		Stroke or TIA		Hallucinations
	Joint trauma		Weakness in arms or legs		Memory change
	Osteoporosis		Paralysis		Change in sleeping habits
	Other _____		Uncontrolled movements (trembling/shakiness)		Recurrent nightmares
VACCINATIONS			Tingling, numbness		Anxiety
Yes	or <input type="checkbox"/> None		Unsteady gait		Panic Attacks
	Hepatitis B		Spinal cord problems		Other _____
	Hepatitis A		Other _____	MALE GU	
	Flu	HEMATOLOGY		Yes	or <input type="checkbox"/> None
	BCG (TB vaccine)	Yes	or <input type="checkbox"/> None		Enlarged prostate
	Pneumonia		Anemia		Prostate Cancer
	Other _____		Low iron		Decreased stream
ALLERGIES			Sickle cell disease		Syphilis
Yes	or <input type="checkbox"/> None		Sickle cell trait		Gonorrhea
	Allergies to medications		Hemophilia		Syphilis
	Reaction to medications		Leukemia or lymphoma		Genital herpes
	Allergy to latex		Bruise easily		Genital warts
	Allergy to dust/pollen		Bleed easily		Chlamydia
	Food allergy		Blood transfusion		Other STD _____
	Allergy to animals		Tested positive for HIV/AIDS		Hernia
	Other _____		Blood clots		Low sperm count
			Thalassemia		Difficulty w/erection
			Other _____		Other _____

1. If you answered yes to any of the selections listed above, please explain below. (If more space is needed please request an extra form.)

PLEASE USE MM/DD/YY FORMAT FOR ANY DATES GIVEN (For Vaccine History only YY is required)

List PROBLEM/SYMPTOM or <input type="checkbox"/> NONE	Onset Date	Date of Last Occurrence	Ongoing	COMMENTS
Example: (Broken right ankle)	(01/15/09)	(03/01/09)	<input checked="" type="checkbox"/>	(Broke ankle from fall - wore cast)

Do not write below tables or on back. If more space is needed please request an extra form.

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2. List ALL past hospitalizations and surgeries: (If more space is needed please request an extra form.)

PLEASE USE MM/DD/YY FORMAT FOR ANY DATES GIVEN

List REASON/ILLNESS or <input type="checkbox"/> NONE Example: (Laparoscopic Inguinal Hernia Repair)	Where (hospital or city)	Date (01/15/09)	COMMENTS (no complications)

3. List ALL Drug Allergies: (If more space is needed please request an extra form.)

PLEASE USE MM/DD/YY FORMAT FOR ANY DATES GIVEN

List DRUG ALLERGIES or <input type="checkbox"/> NONE Example: (Aspirin)	Onset Date (01/15/00)	Date of Last Occurrence (03/01/09)	Ongoing <input checked="" type="checkbox"/>	What happened to you (hives)

4. Have you ever used recreational drugs, marijuana, cocaine, IV drugs or any other drugs? Yes No

What drug(s): \_\_\_\_\_ Date of last use: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

What drug(s): \_\_\_\_\_ Date of last use: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

5. Do you have tattoos? Yes No If YES, list location(s) below:

\_\_\_\_\_

If yes, Date of last tattoo: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

6. Do you have body piercing? Yes No If Yes, list location(s) below:

\_\_\_\_\_

If yes, Date of last piercing: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

7. Do you have any significant birthmarks, scars, or burns? Yes No If Yes, list location(s) below:

Birthmarks: \_\_\_\_\_ Scars: \_\_\_\_\_ Burns: \_\_\_\_\_

8. Do you do any form of exercising? Yes No If Yes, list below:

Type: \_\_\_\_\_ How often: \_\_\_\_\_ Week Month, Date last exercised: \_\_\_/\_\_\_/\_\_\_ (MM/DD/YY)

# Quintiles Phase I Male Medical History

## FAMILY HISTORY

9. Mother's Age \_\_\_\_\_  Alive  Deceased  Unknown      Father's Age \_\_\_\_\_  Alive  Deceased  Unknown

**Does your family have a history of?** (For this section, all questions must be answered as either Yes Or No. Any 'Yes' answers must also include information of the family member.)

YES	NO	DISEASE/CONDITION	FAMILY MEMBER Example: (mother, father, sister)
		Alcohol or drug abuse	
		Asthma or allergies	
		Blood diseases (hemophilia, sickle cell disease, thalassemia)	
		Cancer	
		Diabetes	
		Heart attack or heart disease	
		High blood pressure	
		Kidney disease	
		Mental illness	
		Stroke or TIA	
		Other	

Comments:

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**I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.**

**Volunteer Signature and Date** \_\_\_\_\_     /    /      
(MM/DD/YY)

For Physician Only:

**Investigator Signature and Date** \_\_\_\_\_     /    /      
(MM/DD/YY)

**Investigator:**

**Any clinically significant history relevant to the applicant's participation in the study**  Yes  No

**If yes, please comment:**

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