

ID #: _____
(Internal Use Only)

QUINTILES STUDY PARTICIPATION APPLICATION

Date Rcvd: _____
(Internal Use Only)

Legal First Name: _____ Last Name: _____ Middle Initial: _____ Jr., Sr., II, III _____

Social Security #: _____ Birth Date: _____ Race: _____ Gender: Male Female

Current Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ E-Mail Address: _____

How did you hear about Quintiles? (Check only the one that prompted you to fill out this application)

- Personal referral** Name: _____ **Internet / email**
- TV** **Radio** (Please indicate station): _____ **Newspaper or Publication:** _____
- Outreach Event** (Please indicate event and approximate date): _____

Height: _____ Weight: _____ Frame Size: Small Medium Large Right Handed Left Handed

Do you presently use tobacco? No Yes If yes, # smoked/chewed per day: _____ Duration of tobacco use in # of years: _____

Have you used tobacco in the past? No Yes If yes, # smoked/chewed per day: _____ Duration in years: _____ Date quit: _____

Do you consume caffeine? No Yes If yes, # of caffeine drinks per day: _____ (Cola, Coffee, Tea, or Chocolate)

Do you drink alcohol? No Yes If yes, # of alcohol drinks per week: _____

Do you have a history of drug or alcohol problems? No Yes Date of treatment: _____

Do you presently use illicit drugs? No Yes Date of last use: _____ (Marijuana, cocaine, crack, etc.)

Date of last Blood Donation: _____ Date of last Plasma Donation: _____

FEMALE ONLY

Are you of child bearing potential? No Yes Date of last menstruation: _____

Method of birth control: _____ Date of last Pap Smear: _____

Name of Emergency Contact: _____ Phone #: _____

Are you allergic to any drugs, foods, animals or plants? No Yes If yes, please explain: _____

When did your allergy begin? _____ Types of reactions: _____

Are you on any type of prescription or routine over the counter medications? No Yes If yes, please list below:

Name of Medication	How Much (mgs)	How Often	Reason for Taking	Start Date	Stop Date

Please mark () any condition for which you have ever been **diagnosed** or **treated** by a **physician**. Remember to list the **date the condition began** and provide specific details at the bottom of page.

AUDITORY SYSTEM

- Hearing Loss _____
- Dizziness _____
- Other _____

CANCER

Type: _____

CARDIOVASCULAR

- Angina _____
- Coronary Art. Ds. _____
- CHF _____
- High Cholesterol _____
- Stroke _____
- Hypertension _____
- Heart Attack _____
- Abnormal ECG _____
- Other _____

ENDOCRINE

- Diabetes _____
- Hypo-thyroid _____
- Hyperthyroid _____
- Obesity _____
- Other _____

EYE

- Cataracts _____
- Glaucoma _____
- Visual Acuity _____
- Other _____

GASTROINTESTINAL

- Diarrhea _____
- Constipation _____
- Ulcer _____
- Colitis _____
- Gall Bladder _____

GASTROINTESTINAL cont.

- Liver Disorders _____
- Irritable Bowel _____
- Other _____

HEMATOLOGIC

- Anemia _____
- Blood Clotting Problems _____
- Sickle Cell _____
- Other _____

IMMUNE SYSTEM

- HIV _____
- Auto-immune Disease _____
- Hepatitis B Vaccine _____

MUSCULOSKELETAL

- Head Injury _____
- Osteoarthritis _____
- Rheum. Arthritis _____
- Osteoporosis _____

NERVOUS SYSTEM

- Migraine _____
- Multiple Sclerosis _____
- Parkinson's _____
- Seizure Disorders _____
- Alzheimer's _____
- Other _____

PSYCHE

- Memory Loss _____
- Depression _____
- Manic Depression _____
- Schizophrenia _____
- Sleep Disorders _____
- Anxiety Disorders _____
- Addictive Disorders _____
- Other _____

REPRODUCTIVE - MALE

- Infertility _____
- Impotence _____
- Vasectomy _____
- Other _____

REPRODUCTIVE - FEMALE

- PMS _____
- Endometriosis _____
- Vaginal Infections _____
- Tubal Ligation _____
- Total Hysterectomy _____
- With Ovaries Removed _____
- Partial Hysterectomy _____
- Post Menopausal _____
- Other _____

RESPIRATORY

- Asthma _____
 - Adult _____
 - Childhood _____
- Bronchitis _____
- Emphysema _____
- Hay fever/Sinus _____
- Other _____

SKIN & SOFT TISSUE

- Acne _____
- Hair Loss _____
- Eczema _____
- Psoriasis _____
- Other _____

URINARY SYSTEM

- Kidney Stones _____
- Kidney Infections _____
- Renal Failure _____
- Other _____

For each category checked above, please provide the additional information below:

Diagnosis	Date Diagnosed	Type of Treatment Received	Is the Condition Still Present?

Have you ever been hospitalized, had emergency room treatment, surgery of any type or any other medical problems? No Yes
Please describe:
